[PRACTICE NAME] Authorization and Consent to Participate in Telemedicine Consultation Internal Education

In an effort to mitigate patient and staff exposure to airborne particles that may pose a threat to the safety and wellbeing on the [**city**] and surrounding populations [**Practice**] is deploying Telemedicine service capabilities. This will ensure patients have direct access to a provider or care within our health system without risk of exposure to COVID-19.

This form provides the proper authorization/consent for participation in the telemedicine or video conferencing services and to allow [**Practice**] to provide these services and bill to your insurance company.

Provider Name and Specialty: _____, MD/DO/PA/PA-C/ NP/ARNP

1. Purpose and Benefits. The purpose of this service is to use telemedicine or video conferencing to enable patients who are symptomatic or believe they have had exposure to someone with COVID-19 as well as those patients living in rural and/or underserved areas to get medical care without the inconvenience and expense of traveling to a city.
2. Nature of Telemedicine Consultation: During the telemedicine consultation:
    a. Details of you and/or your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunication technology.
    b. Physical examination may take place.
    c. Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
    d. Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
3. Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine service. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
4. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine services. All existing confidentiality protections under federal and [**State**] State law apply to information disclosed during this telemedicine or video service.
5. Risks and The Need for Further Evaluation: The telemedicine service will be similar to a standard medical office visit, except interactive video technology will allow you to communicate with a qualified provider of medical services remotely. The use of video technology to deliver healthcare and educational services is a newer technology and may not be equivalent to direct patient to provider contact. Following the telemedicine consultation, your provider may recommend a visit to a hospital in [**City**] or another hospital in the area providing specialty care or further evaluation.

6. Your Rights: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment. Revocation of this consent does not create a risk, loss of, or withdrawal of any program benefits for which you would otherwise be entitled.

   If at any time during your Telemedicine Consultation you wish to stop and request an in-person visit, you have that option to consult with a provider of medical services in person.

7. Financial Agreement: This telemedicine consultation will be paid for by your insurance company. However, in the event they refuse payment you may be held finically responsible for any and/or all telemedicine services rendered to you by [**Practice**].

I, _____ have been advised of all the potential benefits and/or risks of telemedicine. My provider of medical care services has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered to my satisfaction to continue with the Telemedicine Consultation.

Signature: _____ Date: _____

Printed Name: _____

Patient (or person authorized to give consent) If signed by person other than patient, provide relationship to patient: _____

Witness: _____ Date: _____