Informed Consent for Telemedicine and/or Telehealth

Name of Patient: _____ Date of Birth: ____/____/____

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

In order to better serve the needs of the community, some health care services are available from the center via telemedicine and telehealth. Telemedicine medical services and telehealth services are health care services delivered by physicians and health professionals to patients located at a different physical location using telecommunications or other information technology. Telecommunications or other information technology may also be used for virtual check-ins, e-visits, initial evaluations, screenings, and pre and post visit communication by center staff. Providers may include, but are not limited to, Physicians, Advanced Practice Registered Nurses, Physician Assistants, Professional Counselors, Marriage and Family Therapists, Clinical Social Workers, and Psychologists.

Information shared may include patient medical records, medical images, medical audio or video files, two-way audio and video, and output data from medical devices. The systems used by the center to transmit and receive this information will incorporate network and software security protocols intended to protect the confidentiality of the patient's identity and information.

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me via telemedicine and/or telehealth.

I understand the following:

- The same standard of care applies to health care services delivered via telemedicine and/or telehealth as applies to an in-person visit.
- The laws that protect the privacy and confidentiality of health care information apply to health care services delivered via telemedicine and/or telehealth.
- I will not be physically in the same room as my healthcare provider. I will be notified of, and my consent obtained, for anyone other than my healthcare provider present in the room.
- There are certain hazards and risks connected with all forms of treatment, regardless of the medium used, and my consent is given knowing this.

- There are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, the visit may be discontinued.
- I have the right to refuse to participate or decide to stop participating in a telemedicine/telehealth visit at any time.
- I understand that this visit may need to be converted into an in-person visit for situations and/or cases that require a physical exam in order to determine a diagnosis and for appropriate treatment and care.
- The center and the center's healthcare providers have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.
- I may consent to my medical record or a report containing an explanation of the treatment provided being sent to my primary care physician.
- This informed consent for telemedicine and/or telehealth is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks to a minimum, risks can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.
5. I hereby voluntarily give my consent to receive health care services via telemedicine and/or telehealth.

_____

[Signature of Patient/Legal Representative]

Print Name: _____

Date/Time: _____

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**

For more information, please visit our website at **www.tmb.state.tx.us**.