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**Informed Consent for Telemedicine Services**

The following provides information about some of the policies and procedures of Student Health Services (SHS). Please read the material and sign it to acknowledge that you understand the information provided. This document will be kept in your SHS patient file. A copy can be provided to you on your request.

**Introduction**

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving the patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education and may include any of the following:

* Patient medical records
* Medical Images
* Live two-way audio and video
* Output data from medical devices and sound and video files

I, for myself (or Minor Patient Legal Representative) understand that my care and treatment during this encounter will be through the use of video conferencing technology.

I understand that a video-visit will not be the same as a direct patient/provider visit because I will not be in the same room as my provider.

I understand that there are alternative methods of medical care available to me.

I understand there are potential risks associated with participating in a video-visit. These risks include, but may not be limited to:

* The electronic connection may not be sufficient to provide the provider(s) with the information necessary to facilitate or make medical decisions.
* The provider(s) are not able to provide for or arrange for any emergency care that I may require.
* Delays in medical evaluation and treatment could occur due to deficiencies or failures of the technology.
* Information transferred electronically may be more vulnerable to disclosure or tampering than information transferred by other means. In rare instances, security protocols could fail.
* A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgment errors.

I understand that the provider or I can discontinue the video-visit if either party believes that the video conferencing modality is not adequate for the situation. I also understand that I may stop or refuse to participate in the video-visit any time without affecting my right to future care or treatment.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the video-visit other than the provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the video-visit and have the right to request the following:

* Ask non‐medical personnel to leave the telemedicine video-visit examination room; and/or
* Terminate the video-visit at any time.

I have read and understand the information provided to me regarding video-visits and am choosing to participate in a video-visit.

I hereby give my consent to the use of a video-visit for purposes of my diagnosis and treatment.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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