

# Informed Consent for Telemedicine Services

## Introduction

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

- Patient medical records
- Medical images
- Live two-way telephone or audio-video communication
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to protect its integrity against intentional or unintentional corruption.

## COVID-19 Public Health Emergency Waiver

As enacted under the 1135 waiver provided by the Secretary of the Department of Health and Human Services and the Health and Human Services Office of Civil Rights (OCR) during the COVID-19 nationwide public health emergency, your health care providers may provide telemedicine services in good faith through everyday communication technologies even though these technologies may not fully comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules and as such may not provide protection of confidential identification or protected medical information. Your health care provider may use audio or video communication technology to provide telemedicine services during the COVID-19 nationwide public health emergency through any non-public facing remote communication product that is available to communicate with patients, such as FACETIME.

## Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the healthcare provider evaluates the patient, obtains test results and obtains necessary consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management without coming into the medical office.
- Obtaining prescriptions for necessary medications that my healthcare provider selects for me.

## Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor audio or visual resolution of images) to allow for appropriate medical decision making by the healthcare provider(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: \_\_\_\_\_

**By signing this form, I understand the following:**

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My health care provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including outside of San Antonio, Texas.
6. I understand that it is my duty to inform my doctor of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I understand that my insurance deductibles and/or co-pays apply to telemedicine services.
9. I understand that during the COVID-19 Nationwide Public Health Emergency my health care provider may use communication technologies that may not be provide protection of confidential identification or protected medical information.

**Patient Consent To The Use of Telemedicine Services**

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize *Vista Dermatology* to use telemedicine services in the course of my evaluation, diagnosis and treatment.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(or authorized signer)

Authorized Signer: \_\_\_\_\_  
(relationship to patient)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_