Telemedicine Services Consent Form

Student Name: _____Date of Birth: _____

Telemedicine/Telehealth 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 patient care. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the healthcare provider. An originating site is the location of the patient beneficiary. The distant site is where the physician or providers of Telemedicine/Telehealth are residing during the time of the consultation. Providers may include primary care practitioners, nurse practitioners, specialists, and/or subspecialists and therapists. The information may be used for diagnosis, therapy, follow-up, and/or education.
I understand that as with any medical procedure, there are expected benefits and potential risks associated with the use of Telemedicine/Telehealth that I need to be aware of.

Expected Benefits include the following:

- Improved access to care by enabling a patient to remain at a remote site while receiving professional care from a healthcare provider.
- More efficient medical and health evaluation and management.
- Patients may be diagnosed and treated earlier which can contribute to improved outcomes and less costly treatments.

Possible Risks include, but are not limited to:

- Despite reasonable safeguarding efforts, the transmission of my child's medical information could be disrupted or distorted by technical failures resulting in delays in evaluation; the transmission of my medical information could be interrupted by unauthorized person; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- Telemedicine/Telehealth based services may not be as complete as face-to-face services. I understand that if my child's Telemedicine/Telehealth provider believes that my child will be better served by another form of services (e.g. face-to-face services) my child will be referred to another provider and it is my responsibility to ensure that referral instructions are followed timely.
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the Telemedicine/Telehealth healthcare provider.
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reaction, or other judgment error.

By signing this form, I understand the following:

1. I give my consent for the sharing of my child's personal health information with PanCare of Florida, Inc and its physicians/providers.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine/Telehealth in the course of my child's care at any time without affecting my child's 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/ Telehealth interaction, and may receive copies of this information in accordance with Florida law.
4. I understand that alternative methods of medical/health care may be available to my child, including face-to-face interaction, and that I may choose another alternative at any time.
5. I understand that I may expect the anticipated benefits from the use of telemedicine/telehealth in my care, but that no results can be guaranteed or assured.
6. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by my child during the course of my child's treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and vulnerable adult abuse.
7. Any cause of action arising out of this service must do so exclusively in Florida and I knowingly waive my right to access any other legal forum.

I have read and understand the information provided above regarding Telemedicine/Telehealth and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telemedicine/Telehealth in my child's medical/ health care.

*Signature of Patient (or person authorized to sign for Patient):*_____ *Date:* _____

If authorized signer, relationship to Patient:_____