

Meadows Psychiatry LLC Telemedicine Consent Form

INTRODUCTION

Telemedicine involves the use of synchronous electronic communications to enable physicians and patients to work together remotely.

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

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain conveniently at home, work, or any other location in the state of Maryland.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

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 resolution of images) to allow for appropriate medical decision making by the physician and consultant(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 reaction or other judgment error.

By signing this form, I attest to and 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 a variety of alternative methods of medical care and treatment may be available to me, and that I may choose one or more of these at any time. My physician has explained the alternatives to my satisfaction.
4. 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.

CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician, 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, and hereby authorize my physician to use telemedicine in the course of my diagnosis, care, and treatment.

Name

Date

Signature