Newark Pediatrics
314 E. Main Street • Suite 101 • Newark, DE 19711
Phone (302) 738-4800 • Fax (302) 738-8750 • www.newarkpediatrics.com

TELEMEDICINE CONSENT FORM

PATIENT NAME:_____DOB_____

Introduction

Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your child's medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, an online examination of your child may take place, and video, audio, and/or photo recordings may be taken.

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Anticipated Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the physician may provide care from a distant site.
- Assist my physician in improving my child's medical care

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:

- Video consultation will not be the same as face-to-face service and may not be as complete.
- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician, or there could be technical problems that affect the visit.
- Although our office uses systems that meet recommended standards to protect the privacy and security of the video visits, the service cannot guarantee total protection against hacking or tapping into the video visits by outsiders. This risk is small, but it does exist.
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

If the video visit does not achieve everything that is needed, then I will be given a choice about what to do next. This can be a follow-up face-to-face visit or a second video visit. I can discontinue using video consultation at any time, including in the middle of a video visit. This will not make any difference in my right to ask for and receive healthcare.

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By Signing this Form, I Understand the Following:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed.
2. I understand that the laws that protect the privacy and security of health information 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 authorization.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my child's care at any time.
4. 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.
5. I understand that any other caregiver that I have previously authorized to bring my child into the office for examination may also be able to authorize telemedicine visits for my child(ren).
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
7. I understand that it is my duty to inform my physician of electronic interactions regarding my child's care that I may have with other healthcare providers.
8. I understand that if my medical insurance coverage is not sufficient to satisfy the medical service charges in full, I will be fully responsible for payment.

Patient Consent to the Use of Telemedicine

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 The Doctors of Newark Pediatrics to use telemedicine in the course of my child(ren)'s diagnosis and treatment.

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

Relationship to patient: _____

Names of Children:

_____ _____ _____

_____ _____ _____

Witness: _____ *Date:* _____