TELEMEDICINE CONSENT FORM

Please fill out this form as completely as possible. It must be sent to our office.

CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, MEDICATION HISTORY, AND HEALTHCARE OPERATIONS

I understand the purpose for this service is to seek medical advice and guidance for the care of my child who does not have an emergency condition. I also understand that at any time if I feel I cannot wait for a visit or feel my child's condition has become an emergency than I will call 911 and/or seek emergent care.

I understand that telemedicine is the use of video communication or telecommunication and other technologies by a healthcare provider at a remote location to deliver services to an individual located at a different physical location than the provider. I understand that, unlike a traditional in-person medical consultation, the provider at the remote location will not have the ability to use senses such as touch or smell in assessing my child's condition.

I understand that telemedicine provides benefits including improved access to specialists and an efficient means of assessment but there are also a number of unique risks associated with telemedicine, which include, but are not necessarily limited to:

- Interruption or disconnection of the audio/video connection resulting in incomplete or delayed assessment.
- Delay in care resulting from communication service or equipment failure.
- Inadequate visual resolution resulting in incomplete assessment.
- Incomplete communication of medical history resulting in adverse drug interactions, allergic reactions, or other adverse result.

In addition to these risks, I understand that the remote provider evaluating my child does not have the opportunity to meet with my child in-person and must rely on information provided by me, my child or the on-site provider. I understand and acknowledge that the remote provider cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me, my child or others.

Just as with a traditional in-person medical consultation, I understand that I will be financially responsible for any charges for my child's telemedicine visit. I understand that my telemedicine visit may not be covered by my insurance plan.

My child and I have had the opportunity to review this information prior to any form of payment being collected. By signing this form, I indicate that I have chosen to proceed with the telemedicine visit for my child.

I understand that the remote provider is a provider at The Children's Clinic of Wyomissing will maintain a record of this telemedicine visit and I may obtain a copy of that record as provided in the Notice of Privacy Practices.

I consent to the healthcare provider I am connected with to providing healthcare services to my child via telemedicine. As long as this consent has not been revoked by me, it remains in effect. The physician may provide healthcare services to my child via telemedicine pursuant to this consent without the need for me to sign another consent form.

By signing below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

- **Patient Name -**
  _____
- **Patient's Date of Birth**
  _____
- **Parent/Guardian Name**_____
- **Relationship**
  _____
- **Signature**_____**Date**_____