

Telemedicine Informed Consent Form

I _____ [name of patient] hereby consent to engaging in telemedicine with _____ [name of doctor/therapist] as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Colorado or outside of Colorado.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; that information shared by phone or internet may not be as confidential as in-person consultation; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my doctor/therapist believes I would be better served by another form of treatment (e.g. face-to-face services) I will be referred to someone who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my doctor/therapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Colorado law.

I have read and understand the information provided above. I have had the opportunity to discuss it with my doctor/therapist, and all of my questions have been answered to my satisfaction.

Signature of patient/parent/guardian/conservator

If signed by other than patient indicate relationship

Date

Signature of doctor/therapist