Informed Consent for Telemedicine Service

Patient Name:_____

Location of Patient: _____

Date of Birth: _____

Patient Number: _____

Provider Name: _____

Provider Location: _____

Date Consent Discussed: _____

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to _____providing healthcare services to me via telemedicine.

I understand the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my provider at 307-578-1955. If this consent is in force (has not been revoked) my provider may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

_____ _____

Signature of Patient (or person authorized to sign for patient **Date**

If authorized signer relationship to patient: _____

_____

Witness: _____ **Date**

I have been offered a copy of this consent form (patient's initials): _____

I understand and agree that any form of electronic signature, including but not limited to signatures via facsimile, scanning, or electronic mail, may substitute for the original signature and shall have the same legal effect as the original signature.

Patient's Initials: _____