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| Patient Name: Location of the Patient: Address: City:State:Zip Code: Cell Phone Number:  | Date of Birth: |
| Practitioners and Staff at **Noblesville Urgent Care,** 509 Sheridan Road, Noblesville, IN 46060; (317) 678-6402 | Date Consent Obtained: |

**Introduction:**

Telemedicine involves the use of medical information exchanged from one site to another via electronic communications. Practitioners and Staff at Noblesville Urgent Care provide services using an interactive audio and video telecommunication system that permits real-time communication to patients who are at some distance from the Practitioners and Staff at Noblesville Urgent Care.

**Purpose**:

The purpose of this telemedicine service is to enable patients to receive medical care by Practitioners and Staff at Noblesville Urgent Care.

**Privacy and Security:**

I understand that for this encounter, electronic systems used will incorporate network and software security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.

**Nature of Telemedicine Consultation:**

I consent to Practitioners and Staff at Noblesville Urgent Care who explained to me how the video and conferencing technology will be used for the purposes outlined below:

1. Discuss and monitor examination/procedure/treatment
2. Diagnosis, follow-up and educational purposes
3. Photo recordings may be taken during the encounter
4. Non-medical technical personnel may be present in the telemedicine area to aid in video transmission
5. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records:**

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.

**Alternatives:**

I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Practitioners and Staff at Noblesville Urgent Care have explained the alternatives to my satisfaction.

**Risks and Consequences:**

The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with Practitioner at a distance. At first, you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct Patient to Practitioner contact. Following the telemedicine consultation, your Practitioner may recommend a visit to nearby Hospital for further evaluation.

**Rights**:

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. 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. I understand that it is my duty to inform my Practitioner of electronic interactions regarding my care that I may have with other healthcare providers.

I have had a direct conversation with Practitioners and Staff at Noblesville Urgent Care, during which I had the opportunity to ask questions concerning telemedicine service. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. All blanks or statements that required completion were completed before I signed this form.

I hereby consent to participation in a telemedicine consultation.

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Patient Witness

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Signature of Authorized Representative Relationship to Patient