

CONSENT TO TELEHEALTH VISIT

Health care provider name \_\_\_\_\_

Clinic name and location \_\_\_\_\_

1. Purpose.

The purpose of this form is to get your consent for a telehealth visit with dermatologists (expert skin doctors) at \_\_\_\_\_ (dermatology department/group). The purpose of this visit is to help in the care of your skin problem.

2. How Telehealth Works.

In a telehealth visit, you will interact in real time with your dermatologist via a secure, online videoconferencing technology. Alternatively, the dermatologist may give you the option of submitting a photo and chief complaint via secured electronic messaging. Your dermatologist has the right to discontinue or not provide a consult via videoconference or secure electronic messaging should the videoconference connection or the forwarded image be of poor quality. You may be required to make an in-person appointment for further evaluation should this occur. The dermatologist will look at the patient's skin during a videoconference or review the photos you submitted. The dermatologist will then give you advice about your dermatologic condition and how to treat and take care of your condition. The information from the dermatologist will not be the same as a face-to-face visit because the dermatologist is not in the same room.

3. Pros, Cons and Your Options.

With telehealth, a dermatologist will advise you based on viewing your condition during a videoconference or based on the photos that were submitted electronically. Sometimes a face-to-face follow-up visit with the dermatologist may still be needed. If you do not come into the office for an in-person visit, the dermatologist's advice will be solely based on the viewing your skin condition during a videoconference or on the information and images provided by you electronically. In the absence of an in-person physical evaluation, the dermatologist may not be aware of certain facts that may limit or affect his or her assessment or diagnosis of your condition and recommended treatment. It is possible that there will be errors or deficiencies in the transmission of the images of your skin condition during the videoconference or in the photos submitted electronically that may impede the dermatologist's ability to advise you about your condition. Also, very rarely, security measures can fail to protect your personal information, but the company that is providing the technology for your telehealth visit has extensive security measures in place to prevent such failures from happening.

4. Presence of Others During Telehealth Visit

People other than your doctor may be a part of the patient's care and present during a telehealth visit. These people may be resident doctors (who have finished medical school and are now completing an "on-the-job" training in an office or hospital), medical students, or nurses. Anyone that is part of the telehealth team will be supervised by the dermatologist, and the final recommendations about your care will come from the dermatologist. Also, non-medical people may help to set up the telehealth equipment. You may ask for persons other than your dermatologist to leave the room if you are uncomfortable having them participate in your telehealth visit.

**5. Medical Information and Records.**

All federal and state laws covering access to your medical records (and copies of medical records) also apply to telehealth. No one other than the health care team described above can view your photos or information unless you agree to give them access.

**6. Privacy.**

All information given at your telehealth visit will be maintained by the doctors, other health care providers, and health care facilities involved in your care and will be protected by federal and state privacy laws.

**7. Your Rights.**

You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

**8. Waiver/Release.**

By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit or in the electronic submission of your images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your dermatologist and his or her institution or practice from any claims you may have about this advice or the telehealth visit generally. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any telehealth visits that occur during the one-year period after your signature date.

**My doctor has talked with me about the telehealth visit. I have had the chance to ask questions and all of my questions have been answered. I have read this form, understand the risks and benefits of the telehealth visit, and agree to a telehealth visit under the terms explained above.**

\_\_\_\_\_  
Signature of Patient

or

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Name of Interpreter / ID #

\_\_\_\_\_  
Relationship of Representative to Patient

\_\_\_\_\_  
Signature of Witness  
*(required if patient is unable to sign)*

\_\_\_\_\_  
Date of Signing

**Refusal:** I do not want to be a part of a telehealth visit.

\_\_\_\_\_  
Signature