**Kentucky Cardiology Informed Consent for Telemedicine Services**

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| --- | --- | --- | --- |
| **PATIENT NAME:** |  | **DATE OF BIRTH:** |  |
| **LOCATION OF PATIENT:**  |  | **PATIENT ID #:** |  |
| **PHYSICIAN NAME:**  |  | **LOCATION:**  |  |
| **DATE CONSENT DISCUSSED:** |  |

**Introduction**

Telemedicine involves the use of electronic communications to enable health care providers at

different locations to share individual patient medical information for the purpose of improving

patient care. Providers may include primary care practitioners, specialists, and/or subspecialists.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include

any of the following:

· Patient medical records

· Medical images

· Live two-way audio and video

· Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols 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.

**Expected Benefits:**

· Improved access to medical care by enabling a patient to remain in his/her cardiologist’s

 office (or at a remote site) while the physician obtains test results and consults from healthcare

 practitioners at distant/other sites.

· More efficient medical evaluation and management.

· Obtaining expertise of a distant specialist.

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine.

These risks include, but may not be limited to:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to

 allow for appropriate medical decision making by the physician and consultant(s).

· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the

 Equipment.

· In very rare instances, security protocols could fail, causing a breach of privacy of personal

 medical information.

· In rare cases, a lack of access to complete medical records may result in adverse drug

 interactions or allergic reactions or other judgment errors.

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**By signing this form, I understand the following:**

1. 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.

2. 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.

3. 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.

4. 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. My cardiologist has explained the

 alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical

 information to other medical practitioners who may be in other areas, including out of

 state.

6. I understand that it is my duty to inform my cardiologist of electronic interactions

 regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my

 care, but that no results can be guaranteed or assured.

**Patient Consent to Use of Telemedicine**

I have read and understand the information provided above regarding telemedicine, have

discussed it with my physician or such assistants as may be designated, and all my questions

have been answered to my satisfaction. I hereby give my informed consent for the use of

telemedicine in my medical care.

I hereby authorize Kentucky Cardiologyto use telemedicine during my diagnosis and treatment.

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| --- | --- | --- | --- |
| ***Signature of Patient***  |  | ***Date:*** |  |
| *(or person authorized to sign for patient):*  |
| ***If authorized signer, relationship to patient****:* |  |
|  |
| ***Witness:*** |  | ***Date:*** |  |

I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_