

## Telemedicine Consent

I authorize Dr. Hayyeri to utilize telemedicine in determining my diagnosis and/or treatment. I understand telemedicine means the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient.

### Benefits

The reason telemedicine is being utilized is for the following reason(s):

- Convenience of encounter for the patient.
- Access to healthcare technology not physically readily available.
- Need for expertise from a consultant not readily available.

### Risks

The reasonably foreseeable risks of utilizing telemedicine technologies may include:

- Audio or visual images may not be as good as in person.
- Telemedicine physician cannot utilize the senses of touch and smell to assist in diagnosis, treatment or therapy.

### Alternatives

The possible alternatives may be:

- Travel distance to physically see consultant or undergo the testing/procedure.
- Undergo therapy available locally which may not produce desired result.

### Confidentiality

I understand every reasonable effort will be made to protect the security and confidentiality of my medical information which is copied and forwarded to the above-named consulting either through the mail or transmitted through electronic means as part of telemedicine.

### Option Not to Participate

I understand I have the option of not participating in telemedicine and can withdraw from participation in utilizing telemedicine technology in my diagnosis or treatment at any time by expressing this to my physician.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

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Patient or Legal Representative Date Witness's Signature Date

PHYSICIAN DECLARATION: I have explained the contents of this document with the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed. The patient has consented.

Physician Signature \_\_\_\_\_

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