HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

Patient Name:	Or
Patient DOB:	Patient
Patient Number:	Label
Admit/Visit Date:	

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine services involve the use of secure interactive videoconferencing software, equipment, and devices that enable health care providers to deliver health care services to patients who are not located in the same location as the healthcare provider. In telemedicine services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education to improve a patient's clinical health status. 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. Health information is exchanged interactively from one site to another through electronic communications.

I understand the following with respect to telemedicine:

1. **Nature of Telemedicine Visit:** I will not be physically in the same room as my health care provider. The same standard of care applies to a telemedicine visit as applies to an in-person visit. I will be notified and given the opportunity to provide consent for anyone other than my healthcare provider to be present in the room.
2. **Rights:** 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 may revoke my consent to participate in telemedicine at any time by informing the medical assistant, nurse, and/or provider and/or by contacting clinic registration.
3. **Expected Benefits:** Telemedicine offers convenient and efficient access to medical evaluation and management.
4. **Possible Risks:** There are potential risks associated with telemedicine, including service interruptions, interception, and technical difficulties. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. If the videoconferencing equipment and/or connection fails and/or is not adequate, my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider.
5. **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine service. The laws that protect my privacy and the confidentiality of my health care information apply to telemedicine services.

My signature below means that:

- I have read or had this form read to me and understand this consent form.
- I have been given all the information I asked for about telemedicine, risks, and other options.
- All my questions were answered.
- I agree to everything explained above.
- If I do not agree with any of the statements above, I have told my treating health care provider.
- I am free to withdraw my consent and not participate in telemedicine.
- I am located in the state of Colorado and will be in Colorado during my telemedicine visit(s).
- I hereby agree to participate in the use of telemedicine in my medical care as is described above and as was explained to me.

Consent obtained verbally via telephone:

Name of Patient or Authorized Representative:

Printed Name of Patient or Authorized Representative	Representative's Legal Status/Authority	Date/Time

Health care team member obtaining telephone consent:

Signature	Printed Name	Date/Time

Witness to telephone consent:

Signature	Printed Name	Date/Time