

Telemedicine Consent Form

I understand that my health care provider Lone Star Neurology wishes me to have a telemedicine consultation. This means that I and/or my healthcare provider or designee will, through interactive video connection, be able to consult with healthcare providers at Lone Star Neurology about my condition.

My healthcare provider has explained to me how the telemedicine technology will be used to do such a consultation.

I understand there are potential risks with this technology:

1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. I may be required to go to the location of the consulting physician if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis.

The benefits of a telemedicine consultation are:

1. You may not need to travel to the consult location.
2. You have access to a specialist through this consultation
3. Other:

I give my consent to be interviewed by the consulting health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained per HIPAA regulations.

I understand that a limited physical examination will take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting health care provider.

I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes.

I hereby release Lone Star Neurology its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.

I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in the telemedicine visit under the conditions described in the document

Patient signature

Date