DT884

Children's Healthcare of Atlanta

TELEMEDICINE CONSENT

PATIENT IDENTIFICATION

1. I understand that my health care provider, _____ (MD, DO, PhD) at _____(current healthcare facility) wishes me/my child to engage in a Children's Telemedicine Visit with Dr. _____.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand this consultation will not be the same as a direct patient care visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue my/my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand my/my child's healthcare information may be shared with other individuals for treatment, healthcare operations, and billing purposes without my written authorization.

5. I understand it may be necessary for others to be present during the consultation other than my/my child's health care team and consulting provider in order to operate the video equipment. These individuals are bound to maintain confidentiality of all information obtained. I further understand that I have the right to request the following when non-medical personal are present to: (1) omit specific details of my/my child's medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

6. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in the telemedicine visit, I understand that some parts of the exam may involve physical tests conducted by the individuals at my/my child's location at the direction of the telemedicine consulting health care provider.

7. During a telemedicine consult, I understand that the responsibility of the telemedicine consulting specialist is to advise my/my child's local practitioner and that his/her responsibility will conclude upon the termination of the video conference connection.

8. I understand that billing may occur from both my practitioner and for any necessary Children's Healthcare of Atlanta equipment, supplies, and healthcare provider fees.

9. I hereby acknowledge that I have been offered a copy of the Children's Privacy Notice and Patient Rights and Responsibilities.

10. I have read this document carefully, understand the risks and benefits involved in a telemedicine visit, had my questions explained to me, and hereby consent to participate under the terms described herein.

_____ _____

Patient/Parent/Legal Guardian Date

_____ _____

Facility Witness/Title Date