Counseling Care Center/ Beloit Health System Informed Consent for Telemedicine Services

Patient Name: _____

Date of Birth: _____ Date consent discussed: _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers to communicate with patients at different locations to provide treatment. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient information and will include measures to safeguard the data and to ensure its integrity.

Expected Benefits:

- Improved access to medical care by enabling a patient to receive treatment from a provider at a remote location.

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 sound or image quality) to allow for appropriate decision-making by the healthcare provider.
- Delays or disruption 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.

By signing this form, I acknowledge that 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 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 provider has explained the alternatives to my satisfaction.
4. 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.

5. I understand that my provider or I may determine that my needs are better suited to in-person care, in which case telehealth services will be terminated and I will be transferred to in-person care.

Emergency Plan

I agree to provide names of emergency contacts, with whom my provider has my permission to communicate in the event that my provider has, or learns that others have, concern for my immediate safety.

In the event of an emergency, contact 911, Rock County Crisis at 608-757-5025, Beloit Health System ED at 608-364-5566 or Counseling Care's after hours on call at 608-364-5686 for additional after hours support.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my health care.

I hereby authorize Counseling Care/ Beloit Health System to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

_____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness: _____ *Date:* _____

I have been offered a copy of this consent form (patient's initials) _____