Telemedicine Consent Form

I hereby authorize the Mind Health Institute, Newport Beach (MHI-NB) and/or the Mind Health Institute, Laguna Beach (MHI-LB) to use telemedicine in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of medical information, both orally and visually, between me as a patient and a physician or other health care provider located remotely in another part of the state or another state altogether.

I understand that I have all of the following rights with respect to telemedicine:

Patient Choice of Care. I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

Access to Information. I have the right to inspect all medical information transmitted during a telemedicine consultation; and may receive copies of this information for a reasonable fee.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine; and that no information or images from the telemedicine interaction which identify me will be disclosed to researchers or other entities without my consent.

Potential Risks. I understand that there are risks from telemedicine, including the possibility, despite reasonable and appropriate efforts, that the transmission of medical information could be disrupted or distorted by technical failures in transmission; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage or medical information generated by this telemedicine consultation in one or more databases could be accessed by unauthorized persons. In addition, I understand that telemedical examinations or care may not be as complete as face-to-face examinations or care and that telemedicine does not negate or minimize the risks that may be inherent in a medical illness or condition. Finally, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.

Consequences. I understand that by consenting to telemedicine my physician may communicate medical information concerning me in our interaction as well as to physicians and other health care providers located in other parts of the state or outside the state.

Benefits. I understand that I can expect benefits from telemedicine, but that no results can be guaranteed or assured. Telemedicine provides me with the continuity of care that otherwise would not have been available.

I have read and understand the information provided above, I have discussed it with my physician or my physician's designee, and all my questions have been answered to my satisfaction.

Signature:_____ Date: _____
(Patient, parent, or legal guardian)

Please print name:_____ Relationship to patient: _____

Witness:_____ Date: _____
(MHI-NB or MHI-LB provider)

