[ ] Great River Health System [x] Southeast Iowa Regional Medical Center [x] FM/WB [ ] FM campus [ ] WB campus [ ] Henry County Health Center	[ ] Family Planning [ ] Rural Health [ ] Non-HBC Clinic [ ] Department Specific	Patient Label

Consent to Participate in Telemedicine Services

Telemedicine allows healthcare providers to evaluate, diagnose, and treat patients at a distance using telecommunications technology. It requires sharing information to help improve your health care.

This information is used for diagnosis, therapy, follow-up or education. It may include:

- Details of your medical history, examinations and diagnostic test results. These may be communicated using interactive video, audio and telecommunication technology.
- You may receive a physical examination from on-site staff at your visit.
- Video, audio and/or photo recordings may be taken of you during the telemedicine visit and stored in your electronic medical record.
- A technical specialist may be present if needed for communication services.

Expected benefits

- Improved access to medical care by enabling you to remain at your local health care site (your home, for example) while the health care provider collects and reviews test results at another site, which may be in another state.
- More efficient evaluation and management of your medical needs.
- Obtaining the expertise of a specialist without having to travel.

Possible risks

As with any medical procedure, there are possible risks associated with the use of telemedicine. These risks may include, but are not limited to:

- Medical evaluation or treatment may be delayed because of failure of equipment or technical services.
- The provider may decide the transmitted information is of poor quality, requiring the telemedicine visit to be rescheduled or a face-to-face visit with your local provider be scheduled.
- Security processes could fail, causing a breach in the security of personal information.
- Not having access to your complete medical record may result in adverse drug interactions, allergic reactions or other errors.

I understand my participation in telemedicine is voluntary. I may refuse to participate or decide to end my participation at any time. I understand that my refusal to participate, or my decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of withdrawing my consent to participate in telemedicine services.

I understand providers at the remote site and the local site may have access to relevant clinical information including mental health information, and alcohol and/or drug abuse information.

I understand Great River Health System will use electronic systems that include network and software protocols to protect my personal health information.

I have read this document and received information about the process and telemedicine providers. I hereby consent to participate in services using telemedicine under the terms described above. I understand this document will become a part of my medical record.

Please check the appropriate line:

_____ I want to participate in and receive services through telemedicine.

_____ I do not want to participate in telemedicine services, and I understand the Consequences.

_____ _____

Patient Signature Date/Time

_____ _____

Witness Signature Date/Time

_____ Patient is a 48 hour hold or court committal. No signature required. Refer to Legal documentation on file.

_____ It has been determined the patient is unable to sign and, with attempt made, a Legal guardian or personal representative is not available or accessible.

It has been determined the patient is medically unable to give informed consent and a legal guardian or personal representative is available. Please complete:

The above consent is accepted and given on behalf or _____
Because it has been determined the patient is medically unable to give informed consent.

_____ _____

Legal guardian or personal representative Date/Time

_____

Relationship to patient

_____ _____

Witness Signature Date/Time

Check if applicable: _____ telephone/verbal consent (witnessed by two staff members)

_____ _____

Witness Signature Date/Time

_____ _____

Witness Signature Date/Time