

BIRMINGHAM MAPLE CLINIC

INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME:	DATE OF BIRTH:	CASE NUMBER:
PROVIDER NAME:	LOCATION:	DATE CONSENT DISCUSSED:

Introduction

Telemedicine involves the use of electronic communications to link patients with health care professionals in different locations for the purpose of improving access to care. Providers may include physicians, mental health care providers, and other licensed health care professionals. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data, and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health care by enabling patients to communicate with their providers remotely.
- More efficient health care evaluation and management.
- Obtaining expertise of a distant specialist or consultant, if necessary.

Possible Risks:

As with any health care treatment, 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 resolution of images) to allow for appropriate responses by mental health care providers and consultant(s) (for example, body language may not be conveyed in low-quality images);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of protected health information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial after reading this page: _____

By signing this form, 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. I must provide written notification of my withdrawal of this consent to the following individual: Ms. Lori K. Edelson, LMSW, LMFT, Birmingham Maple Clinic, 2075 W. Big Beaver Road, Suite 520, Troy, Michigan 48084.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, except as otherwise limited by state and federal privacy laws, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of mental health treatment may be available to me, and that I may choose one or more of these at any time. My mental health care provider has explained the alternatives to my satisfaction.
5. 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.
6. I understand that there are potential risks to the use of telemedicine, including interruptions, unauthorized access and technical difficulties. I understand my provider or I can discontinue the telemedicine consult/visit if it is felt that the technology being used is not adequate for the situation.
7. I understand that telemedicine is not to be used in the case of a mental health emergency.
8. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my mental health care 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 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) _____