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Chris D Bock DPM

Telemedicine Patient Consent/Refusal Form

PATIENT NAME: ____
DATE OF BIRTH: ___________________

1. **PURPOSE:** The of this form is to obtain your consent to participate in telemedicine consultation in connection with the following procedures(s) and/or service(s)
   ____
   ____
2. **NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:**
   a. Details of your medical history, examinations, x-ray, and test will be discussed with other healthcare professional through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recording may be taken of you during the procedure(s) or services(s)
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation.
   Please note not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALTY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telemedicine consultation, and all existing confidentiality protections under federal and Washington state law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care of treatment, or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in Washington, and that Washington law shall apply to all disputes.
   RISK, CONSEQUENCES BENEFITS: You have been advised of all the potential risk, consequences and benefits of telemedicine. Your health care practitioner has discussed with you information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered and you understand the written information provided above.

(Consent)

I agree to participate in a telemedicine consultation for the procedure(s) described above.
Signature: _________________________ Date: ______________________________________
If signed by someone other than the patient, indicate relationship: ____________________

(Refuse Telemedicine)

I refuse to participate in a telemedicine consultation for the procedure(s) described above.
Signature:____
If signed by someone other than the patient, indicate relationship: ____________________

**************************Office use only ***

Date: _________________________________ Time:___________________________________
Witness: ____