ROSALIND FRANKLIN UNIVERSITY
HealthClinics

INFORMED CONSENT FOR TELEHEALTH SERVICES

Patient Name:	Provider Name:
Location of Patient:	Location:
Date of Birth:	Date Consent Discussed:

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby give consent to the providers at Rosalind Franklin Health Clinics to provide health care services to me via telemedicine.

My health care provider has explained to me how video conferencing technology will be used during Rosalind Franklin University Health Clinic telemedicine services. I understand that the session will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I may discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. . I understand that the Rosalind Franklin University Health Clinics will enforce and remain HIPAA compliant at all times. As always, I know that my insurance carrier will have access to my medical records for quality review/audit. I understand that I will be responsible for any co-payments or co-insurances that apply to my telemedicine visit and agree to pay in full at the beginning of the session.

I understand that the paperwork I signed with Rosalind Franklin University Health Systems, including initial intake paperwork, HIPAA and privacy policy, signed release of information, and copays and rates/fees also apply to telemedicine services. 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 may revoke my consent orally or in writing at any time by contacting Rosalind Franklin University Health Clinics or my provider directly. As long as this consent is in force (has not been revoked) Rosalind Franklin University Health Clinics may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or authorized representative) _____

Date: _____

If authorized signer, relationship to patient: _____
Date:_____