LOUISIANA HOSPITAL ASSOCIATION
TRUST FUNDS
Administered by HSLI

TELEMEDICINE PROGRAM

Telemedicine Patient Consent Form

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. I have been informed of the current public health order that directs healthcare providers to transition in-person healthcare services to telemedicine technology when medically appropriate. I understand that in the medical opinion of my healthcare provider the delivery of services via telemedicine will be consistent with the standard of care for an in-person visit. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person. My health care provider has explained to me how the video conferencing technology will be used and that there may be limitations and restrictions to the visit which include, for example: no physical examination being conducted and no instruments will be used such as stethoscopes, otoscopes.

I understand there are potential risks to this technology, such as interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.I am aware of how to contact my provider in the event technical difficulties do occur as well as for follow up, emergency care or to obtain copies of my medical records.

By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

Patient Consent To Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Signature of patient (or parent/guardian): _____ Date: _____
Please print the above name: _____
Signature of witness: _____ Date: _____

☐ (CHECK AND SIGN BELOW FOR WITHDRAWAL ONLY). I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): _____ Date: _____
Signature of witness: _____