

## **INFORMED CONSENT FOR TELEMEDICINE CONSULTATION**

### **Introduction**

I, \_\_\_\_\_, agree to receive treatment via a telemedicine consultation, which has been explained to me by \_\_\_\_\_ on \_\_\_\_\_, 20\_\_.

### **Description of Telemedicine Consultation**

I understand that the telemedicine consultation requires me and my healthcare provider to communicate information interactively through video equipment, about my health, including prior health history, present complaints, and laboratory and diagnostic data, to another health care provider at \_\_\_\_\_ Hospital/Health Care Center (“the Facility”). The consultation will take one hour or less for me to complete. I understand that support personnel may be in the room during the consultation to help with the transmission of the video.

I understand that the consultation being provided by telemedicine is provided because of the unavailability of an onsite specialist.

I understand that the treatment I receive via the telemedicine consultation will be the same type of treatment I would receive from an onsite health professional.

I understand that the responsibility for the operation of the technology involved in the telemedicine consultation occurring at the Facility remains with the Facility, and the responsibility for the operation of the technology involved in the telemedicine consultation at WVU remains with WVU.

I understand that the performance of the telemedicine consultation relies on various technologies, the operation of some of which is beyond the control of either WVU or the Facility.

I understand that if, for any reason, the telemedicine consultation cannot be performed, I will be referred to another health professional for a consultation.

### **Risks and Discomforts**

There are no known or expected risks from participating in this consultation.

### **Alternative**

I understand that I may withdraw my permission at any time to participate in this therapeutic medium and that I then will be referred to another health professional.

**Benefits**

I understand that this consultation will directly benefit my healthcare by providing me with services otherwise not available at the Facility.

**Contact Persons**

For more information about the technology used in the telemedicine consultation, I can contact Mountaineer Doctor Television, at (304) 293-6926. For any questions about the care I receive, I should contact my healthcare provider at the Facility.

**Confidentiality**

I understand that any information about me obtained as a result of my participation in this consultation will be kept as confidential as legally possible. I understand that my telemedicine records and test results, just like hospital records, may be subpoenaed by court order or may be inspected by federal regulatory authorities without my additional consent.

I understand that both WVU and the Facility are committed to implementing the regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which protect the confidentiality, integrity, and availability of all electronic protected health information related to my care.

**Voluntary Participation**

I understand that participation in this telemedicine consultation is voluntary. I understand that I am free to withdraw my consent to participate in this consultation at any time, and that such refusal to participate will not affect my future care. Refusal to participate or withdrawal will involve no penalty to me. I have been given the opportunity to ask questions, and I have received answers concerning areas I did not understand. In the event new information becomes available that may affect my willingness to continue to participate in telemedicine consultations, this information will be given to me so I may make an informed decision about my participation.

I willingly consent to participate in this consultation.

\_\_\_\_\_  
Signature of Patient or Patient’s Legal Representative      Date

\_\_\_\_\_  
Signature of Witness      Date