BEHAVIORAL MEDICINE ASSOCIATES
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- **Pain Management**
- **Telemedicine Consultation and Programs Development**
- **Clinical Pharmacology**

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Telemedicine Patient Consent for Electronic Transmission of Information

I, (name of patient or parent/guardian) _____, agree to participate in real-time telemedicine/video conference consultations. My doctor or health care provider has recommended these teleconsultations as a way to facilitate my care. In order to perform the teleconsultation, the teleconsultant will review information supplied by my primary health care provider, about my condition. My health care provider will decide what information will be transmitted. The information will be transmitted electronically. Electronic transmission of information utilizes protected, secure and dedicated communication lines. Information to be transmitted may include patient reports, laboratory results, radiograph reports and photographs. For all consultations, I will be asked to meet with the teleconsultant via secure videoconferencing. Many "secure" video conference software/hardware applications are available. Tele Behavioral Medicine Associates will make every effort to assure security and the maintenance of confidentiality. It is understood that the patient has the final say regarding security and can revoke this consent at any time for any reason. In all situations, my health care provider will receive the teleconsultant's report and will be able to review their recommendations with me (the patient).

By signing this agreement, I authorize the electronic transmission of my medical information and/or a videoconference session (s). Only the teleconsultant in these telemedicine consultations (s) will have access to this information. I have been advised that the likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small, yet not guaranteed.

I understand that I can withdraw my permission to participate in a telemedicine consultation (s) at any time. Although I may choose not to answer any questions that I consider being inappropriate or am unwilling to have heard by other persons. I understand that if I choose not to participate in the telemedicine consultation (s), no action will be taken against me. I am always at liberty to pursue a face-to-face consultation.

I understand that medical records of telemedicine services will be kept with the teleconsultant's office. Copies of teleconsultation notes/or reports will be forwarded to the referring health care provider unless otherwise specified in writing by the patient. If I want to obtain copies of my records, I am entitled to them and need merely to request same from the tele consultant.

Signature of patient (or parent/guardian) _____Date:_____

Please print above name_____

Signature of witness: _____Date:_____

SIGN BELOW FOR WITHDRAWAL OF THIS AGREEMENT ONLY. I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian) _____Date:_____

Signature of witness: _____Date:_____

RESEARCH PURPOSES

I also agree to have my telemedicine records and clinical data reviewed for the purposes of evaluation (data collection, analysis, and presentation in verbal or written format at scientific meetings or publications) or other educational purposes. I understand that any presentation will not identify me by name or other identifiable markers. AGREE_____ (initials of patient only if AGREEING).