CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Telemedicine involves the use of electronic communications to enable health care providers evaluate, diagnosis, manage and treatment of a number of health care problems. Providers may include primary care practitioners, specialists, and/or subspecialists.

I wish to participate, as a patient, in a telemedicine consultation at Plastic Surgery Services of Fredericksburg.

By signing this form, I _____ *understand the following:*
Name

1. The consulting health care provider or specialist will be at a different location from me. My health care provider, Dr. Heppe, Dr. Bautista, or Dr. Aflaki, board certified by the American Board of Plastic Surgery, and such assistants as may be selected, will communicate by interactive video conferencing.

2. I reside in the State of Virginia and am currently in Virginia (during this consultation), where my health care professional is licensed.

3. The presenting health care provider or professional health care staff will see details of my medical history.

4. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

5. I understand that I have the right to 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.

6. I understand that telemedicine may involve electronic communication of my personal medical information.

7. A record of the consultation will be kept in my medical record.

8. I understand, and hold harmless Plastic Surgery Services of Fredericksburg, there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.

9. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured

I have read and understand the information provided above regarding telemedicine. I herby give my informed consent for the use of telemedicine in my health care.

_____ _____ _____
Patient Signature Patient Printed Name Date

_____ _____
Physicians Signature Date