Consent for Telemedicine Services

Telemedicine is the delivery of healthcare services using technology when the healthcare provider and patient are not in the same physical location.

Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically transmitted information may be used for diagnosis, therapy, follow up and/or patient education, and may include any of the following:

- patient medical records
- medical images
- interactive audio, video, and/or data communications
- output data from medical devices and sound and video files

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Potential Benefits:
1. Improved access to medical care by enabling a patient to remain at home or a site remote from the provider's office.
2. Obtaining the expertise of a distant specialist.

Potential Risks:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:
1. Information transmitted may not be sufficient, e.g., poor resolution of images, to allow for appropriate medical decision making by the provider(s).
2. The consulting provider(s) are not able to provide medical treatment to the patient using telemedicine equipment nor provide for or arrange for any emergency care that the patient may require.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.
5. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgment errors.

Alternative: Seek in-person medical care.

I confirm that at the time of the visit, the patient is physically located in Maryland, DC or Virginia. I give consent to participate in a telemedicine visit with a provider at Bay Area Pediatrics, LLC. I understand that this consent remains in place unless revoked by me in writing.

_____
Patient Name and DOB

_____ _____
Signature of Parent/Guardian/Patient Date

_____
Printed Name of Parent/Guardian/Patient