



Kentucky Counseling Center

## TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian)

\_\_\_\_\_, agree to participate in a telemedicine evaluation and/or ongoing treatment performed by an independently contracted provider who assumes sole responsibility and liability for treatment. 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. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small]. I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. 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. 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. I understand that medical records of telemedicine services will be kept at Kentucky Counseling Center. I understand that some or all of my medical information may be used for teaching or educational purposes. I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers.

Signature of patient (or parent/guardian):

\_\_\_\_\_ Date: \_\_\_\_\_

Please print the above name:

\_\_\_\_\_