AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with our Schaumburg Dermatology Medical Providers.

1) Purpose and Benefits: The purpose of this project is to use telemedicine to enable patients to get medical care by specialists during the COVID-19 pandemic.
2) Nature of Telemedicine Consultation: During the telemedicine consultation: a) Details of you and or your child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunications technology. b) Physical examination of you or your child may take place. c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission. d) Video, audio, and or digital photo may be recorded during the telemedicine consultation visit.
3) Medical Information and Records. All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
4) Confidentiality: Reasonable and appropriate efforts are made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Illinois State law apply to information disclosed during this telemedicine consultation.
5) Risks and Consequences: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first, you may find it awkward or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to medical provider contact. Following the telemedicine consultation, your provider may recommend a visit to our clinic for further evaluation.
6) Rights: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment... You have the option to consult with the specialist in person if you schedule an appointment and travel to our location.
7) Financial Agreement: You and or your insurance company will be billed for this visit. The financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance claims for you, we are not responsible for any limitations in coverage that may be included in your plan. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. I have been advised of all the potential risks, consequences, and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all my questions have been answered. I understand the written information provided above.
This consent is valid unless canceled in writing by the patient.

Signature:_____ Date:_____
Patient (or person authorized to give consent) If signed by person other than patient, provide relationship to patient: _____
Witness:_____ Date:_____