TELEMEDICINE CONSENT FORM

I am aware about the purpose of this form is to obtain my consent to participate in a telemedicine consultation

I am aware that this is an alternative method of obtaining opinions and suggestions for providing health care services and may not be as equivalent as to an in-person visit.

I AM AGREEING TO-

- **Authoriz*es* Dr Vijay D`Silva to use telemedicine in the course of my diagnosis and treatment.**
- **I understand that telemedicine involves the communication of my medical information, both orally and visually, to distant healthcare consultants of through a telemedicine coordinator.**
- **I agree to be interviewed during this consultation. Other medical personnel/ paramedical personell may be present during the telemedicine consultation.**
- **I agree to allow non-medical technical personnel to be present to help with the video transmission.**
- **All personnel will be informed of my right to privacy and confidentiality regarding my medical condition and any treatments or interventions I may receive.**

BY SIGNING THIS CONSENT I AM AGREEING THAT-

- **Details of my medical history, examination, X-rays, ECG reports, angiography images etc will be discussed and transmitted via interactive videoconferencing equipment.**

MY RIGHTS

- **By signing this consent, I know that I have the right to refuse to take part, limit, or to stop taking part in this interaction at any time**

- **Laws protecting the confidentiality of medical information also apply to telemedicine and that no information or images from the telemedicine encounter that identify me will be disclosed to other entities without my consent.**

- **I am aware that the call for this consultation / counseling will/maybe be recorded for the medical record purposes and I have no objection for the same.**

POTENTIAL RISKS -

By signing this consent, I understand that

- **Telemedicine may not cure or improve my condition.**
- **Communications may be interrupted because of equipment or power failure.**
- **Records may be lost due to failure of electronic equipment.**
- **My privacy may be compromised by invasion of electronic records by outsiders ("hackers") who overcome industry standard security measures.**

I /we also agree to co-operate fully with the doctor and to follow to the best of my /our patient's ability his / her instruction and recommendations about my / our patient's care and treatment.

STATEMENT OF UNDERSTANDING

By my / our signature on this form I / we reconfirm:

- **That I /we have read and understood the information provided.**
- **I agree to take part in this telemedicine consultation of my own free will.**
- **I confirm that I have read this consent carefully and understand the information provided above.**
- **I agree to accept the possible loss of patient-provider privacy that may occur with this methodology.**
- **I declare that I am more than 18 years of age.**
- **I / we signed this consent voluntary out of my / our free will without any pressure and in my / our full senses.**

This Informed Consent will remain in effect for all future telemedicine consultation with Dr Vijay D`Silva unless I provide a written notice of the withdrawal of this consent.

Date : _____ **Time :** _____

	Patient	**Relative***	**Witness**
Name:	_____	_____	_____
Signature:	_____	_____	_____

***Relationship with Patient:** _____

Address/ ~~phone no -~~ _____

_____