INFORMED CONSENT OF TELEMEDICINE SERVICES
VENTURA COUNTY HEMATOLOGY ONCOLOGY SPECIALISTS

Telemedicine allows healthcare providers to continue to provide medical care to patients who are unable to come to the office for a face-to-face appointment. Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, consultation, treatment, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files
- Communication via the patient portal

The expected benefits of Telehealth include:

- Improved access to medical care by enabling a patient to remain in his/her home while the physician consults and obtains test results at distant/other sites.
- Reduced risk of infection from leaving home during the COVID-19 pandemic.
- Obtaining expertise of a distant specialist.

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of physical exam could lead to a delay in diagnosis or other judgment errors;

By signing this form, you acknowledge that you understand and agree with the following:

1. 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 without my written consent.
2. I understand that I have the right to withhold or 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.
3. 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.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that my insurance will be billed for the Telemedicine visit. The fee will depend on service provided.
6. 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 **CONSENT** to the use of Telemedicine

NAME:_____

SIGNITURE: _____

DATE:_____

☐ I **DECLINE** the use of Telemedicine

NAME: _____

SIGNITURE: _____

DATE: _____