UROLOGIC SPECIALISTS

TELEMEDICINE INFORMED CONSENT FORM

I ______________________________ [patient/guardian name] hereby consent to engaging in telemedicine as part of my urology care.

I understand that I have the following rights with respect to telemedicine:

1. I understand that my health care provider may choose to engage in a telemedicine consultation and that it is my right to revoke the option for "telemedicine" at any point during my care.
2. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
3. I understand that, with my signed consent, telemedicine also involves the communication of my medical information, both orally and visually, to health care practitioners located in Oklahoma and/or outside of Oklahoma.
4. I understand that if this technology is used for care in the future that my health care provider will explain to me how the video conferencing technology will be used and that the affect, such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
7. I also understand that my insurance if applicable will be billed for this service and that I may be billed for any copay, deductible, out of pocket expenses based on my insurance coverage if applicable.
8. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
9. The laws that protect the confidentiality of my medical information also apply to telemedicine.
10. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
11. I understand that I have a right to access my medical information and copies of medical records in accordance with state laws.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).

______________________________	______________________________
PATIENT NAME	DOB
______________________________	______________________________
Signature of Patient or Legal Representative	Date
______________________________	______________________________
Printed Name of Legal Representative if applicable	Relation to Patient

(03/20)