Patient Name: _____ **Account #:** _____ **Today's Date:** _____

Telemedicine Consent Form

I hereby authorize Dr. J. Joseph Prendergast 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 physicians and other health care practitioners located in other parts of the state or outside of the state.

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

1. **Free Choice.** I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

2. **Access to Information.** I have the right to inspect all medical information transmitted during a telemedicine consultation, and m ay receive copies of this information for a reasonable fee.

3. **Confidentiality.** I understand that the laws that protect the confidentiality of medical information apply to telemedicine, and that no information or images from the telemedicine interaction which identify me will be disclosed to researchers or other entities without my consent.

4. **Potential Risks.** I understand that there are risks from telemedicine, including the following: 1) Loss of records from failure of electronic equipment, 2) power failures with loss of communication, 3) invasion of electronic records by outsiders (hackers). **Finally**, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.

5. **Consequences.** I understand that, by having my consent to telemedicine, my physician will communicate medical information concerning me to physicians and other health care practitioners located in other parts of the state or outside the state.

6. **Benefits.** I understand that I can expect the following benefits from telemedicine, but that no results can be guaranteed or assured: 1) Reduced visit time, 2) rapid innovation of treatments, 3) focused information.

I have read and understand the information provided above, I have discussed it with my physician or my physician's designee, and all my questions have been answered to my satisfaction.

_____

Signature Date

_____

Print Name

If not signed by the patient, please indicate relationship: _____

Please print this page and mail or fax it to:

Endocrine Metabolic Medical Center
805 Veterans Blvd., Suite 100
Redwood City, CA 94063
Fax: (650) 368-1570