

Memorial Hermann Health System

Telemedicine/Telehealth Informed Consent Form

I _____ [name of patient] hereby consent to engage in telemedicine/telehealth with a Physician, Psychiatrist, Advance Practice Provider (such as an Advance Practice RN or Physician's Assistant), or health care provider as part of my assessment. I understand that "telemedicine/telehealth" includes the practice of medical care, delivery, diagnosis, consultation, treatment, transfer of medical data, and education by a healthcare provider who is physically located at a site other than where I am located ("distant site provider") using interactive audio, video, or data communications. Telemedicine/telehealth requires the use of advance, telecommunication technology, such as computers and video conferencing software, located on a secure network that allows the distant site provider to see and hear in real time. The Telemedicine/telehealth interaction will not be recorded or saved.

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

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. However, I understand there may not be another Physician or Advance Practice Provider available at the clinic to see me except by using telemedicine/telehealth. If I choose not to receive care using telemedicine/telehealth, an appointment can be rescheduled to be seen onsite when an appointment becomes available.
- (2) I understand telemedicine/telehealth has limitations, risks, and consequences including, but not limited to, the possibility, despite reasonable efforts on the part of the health care provider and that:
 - a. An adverse reaction to the treatment could occur.
 - b. The use of telecommunications or information technology may be unable to provide all pertinent, clinical information required for an acceptable level of quality and delivery of safe care. Some examples might include:
 - The video picture or other information transmitted may not be clear enough to be useful for consultation.
 - The video connection may not work or may stop working during the consultation
 - c. In the event, the provider is unable provide safe care via telemedicine/telehealth, I will be informed prior to the end of the evaluation. I further understand that should the provider be unable to see me via telemedicine/telehealth, I will need an additional in-person evaluation.

Follow-up Care: If the telemedicine/telehealth encounter does not allow for the safe delivery of care, clinic staff will notify me and take the steps necessary for provider services to be delivered in person. If you experience an adverse reaction, please contact the clinic or, in cases of an emergency, dial 9-1-1.

NOTICE CONCERNING COMPLAINTS: Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information, please visit our website at www.tmb.state.tx.us.

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The benefits of a telemedicine/telehealth consultation include, but are not limited to:

- a. Immediate access to a Physician, Advance Practice Provider, or other health care provider.
 - b. Obtaining expertise of a specialist.
 - c. More efficient health evaluation and management.
- (3) The laws that protect the confidentiality of my medical information also apply to telemedicine/telehealth. As such, I understand the information disclosed by me during the course of my assessment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and what is dependent, adult abuse; and medical information about you will be disclosed when required to do so by federal, state or local law.
- (4) I understand that I may benefit from telemedicine/telehealth, but that results cannot be guaranteed or assured.
- (5) I understand that I have a right to access my medical information and copies of medical records in accordance with state and federal law.

I have read and understand the information provided above, all of my questions have been answered to my satisfaction, and I voluntarily and freely consent to receiving care using telemedicine/telehealth under the conditions described in this document.

Patient / Guardian Signature Print Name Relationship to patient Date

Patient unable to sign due to: _____

Witness Signature (must be a health care professional) Print Name Date Time
AM
PM

Institution Name Address (Street or P.O. Box), City and State

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