Brookwood Dermatology (205) 824-4441

Name: _____ Date: _____

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable Brookwood Dermatology and Dr. Herzog, to provide care to you at a remote site, via several technologies, including:

- **Patient medical records**
- **Medical images**
- **Live two-way audio and video**
- **Output data from medical devices and sound and video files**
- **Improved access to medical care by enabling a patient to remain in his/her remote site while the physician renders care remotely**
- **More efficient medical evaluation and management**
- **Obtaining expertise of an additional specialist, if needed**

Possible Risks:

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

- **In rare cases, information transmitted may not be enough (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultation(s);**
- **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 access to complete medical records may result in adverse drug interactions or allergic reactions or other judgement errors;**

By signing this form, I understand the following:

1. **I understand that I am responsible for all applicable co-pays, coinsurances and deductibles if the telemedicine encounter is billed to my insurance, and that such co-pays and coinsurance.**
2. **I understand that the laws that protect privacy and the confidentiality of medical information (HIPPAA) also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.**
3. **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.**
4. **I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.**

5. **I understand a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.**
6. **I understand that telemedicine may involve electronic communication of personal medical information to other practitioners who may be in other areas, including out of state.**
7. **I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.**
8. **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.**
9. **I understand that an in person follow up visit may be warranted.**

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for use of telemedicine in my medical care. I hereby authorize Brookwood Dermatology to use telemedicine in the course of my diagnosis.

_____ _____

Patient Signature **Date**