Annex K

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with the following physician: _____

Purpose and Benefits. The purpose of this service is to use telemedicine to enable patients to still receive health services even while staying at home during the enhanced community quarantine, except for serious conditions, emergencies, or to avail of COVID-19-related health services as per standing protocols.

Nature of Telemedicine Consultation: During the telemedicine consultation:

a) Details of you and/or the patient's medical history, examinations, x-rays, and tests will be collected and discussed with other health professionals through the use of interactive video, audio and telecommunications technology if needed.
b) Physical examination of you or the patient may take place.
c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission, if needed.
d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

Medical Information and Records. All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized by existing law, policies and guidelines on privacy and data protection.

Confidentiality. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. Organizational, physical and technical security measures are in place to ensure that all information processed during the consultation will remain confidential and only authorized personnel will have access to such information on a need-to-know basis. All existing laws, policies and guidelines on privacy and data protection apply to information disclosed during this telemedicine consultation.

Potential Risks and Consequences. The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. As any medical procedure, there may be potential risks associated with the use of this technology. These risks may include, but may not be limited to:

a. Information transmitted may not be sufficient to allow for a conclusive consultation by specialist. Following the telemedicine consultation, your physician may recommend a visit to a health facility for further evaluation.
b. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
   Security protocols could fail, causing a breach of privacy of my confidential medical information.
c. A lack of access to complete medical records may result in errors in medical judgement.
d. There is no guarantee that this tele-consultation will eliminate the need for me to see a specialist in person.

Rights. You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the physician in person if you travel to his or her location.

Financial Agreement. You and/or your insurance company will not be billed for this visit.

I have been advised of all the potential risks, consequences and benefits of telemedicine. The physician of this telemedicine consultation has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:

_____ Date:_____
Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient: _____

Witness: _____ Date:_____