Pediatric Center for Wellness P.C.

1506 Klondike Rd, SW
Suite 205
Conyers, GA 30094
Phone #: 678-750-4000 *Fax #: 678-750-4005*

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

1. **PURPOSE.** The purpose of this form is to obtain your consent for a telemedicine consultation with a provider of Pediatric Center for Wellness.

The purpose of this consultation is to assist in the diagnosis or treatment of most acute visits.

2. **NATURE OF TELEMEDICINE CONSULTATION**. Telemedicine involves the use of audio, video, or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education.

During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio, and telecommunications technology.

3. **RISKS, BENEFITS AND ALTERNATIVES.** The benefits of telemedicine include having access to medical provider and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment.

Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a provider.

4. **MEDICAL INFORMATION AND RECORDS**. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

5. **CONFIDENTIALITY.** All existing confidentiality protections under federal and Georgia law apply to information used or disclosed during your telemedicine consultation.

6. **RIGHTS.** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment,

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or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

AGREEMENT SIGNATURES

My health care provider 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 have read and agreed to a telemedicine consultation.

Signature of Patient or Patient's Representative _____

Date _____

Patient ID # _____