
## CONSENT TO PARTICIPATE IN TELEMEDICINE HEALTH SERVICES

The purpose of this form is to obtain your consent to participate in a telemedicine health service provided by Desert Peaks Health Care (DPHC) in connection with the following services or procedure(s) provided.

**1. NATURE OF TELEMEDICINE HEALTH SERVICE:** During the telemedicine health service:

- Details of your medical history, examinations, x-rays, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
- Visual and physical examination of you may take place.
- Nonmedical technical personnel may be requested to enter the area where telemedicine is being performed.
- Video, audio and/or photo recordings may be taken of the encounter(s).

**2. MEDICAL INFORMATION AND RECORDS:** All existing laws regarding privacy and security of your health information and copies of your medical records apply to this telemedicine health service and the audio and video information transmitted, received and stored electronically as part of this service. Any dissemination of patient-identifiable images or information from this telemedicine interaction to researchers or other entities for purposes other than your treatment, payment for healthcare services you receive, and certain necessary administrative and operational activities supporting your care shall not occur without your authorization.

I acknowledge that I have previously been provided a Notice of Privacy Practices and HIPAA compliance notice by Desert Peaks Health Care _____ (initial)

**3. RIGHTS**: You may withhold or withdraw your consent to the telemedicine health service at any time before or during the consult without affecting the right to future care or treatment. You may also withdraw consent to extra personnel participating in telemedicine health services. You may also revoke your consent to allow DPHC to store and use the video images and audio recordings. The request to revoke consent my be in writing and received by DPHC. If you revoke your consent, the video images and audio recordings will be destroyed and no longer used by DPHC. Any uses of the video made with your permission prior to DPHC's receipt of revocation cannot be changed or undone. To revoke your consent to DPHC's storage and use of video images and audio recordings of your telemedicine health service, please send a written request to:

Desert Peaks Health Care
1555 SW Reindeer Ave
Redmond, OR 97756

**6. DISPUTES**: I agree that any dispute arriving from the telemedicine consult will be resolved in Oregon, and that Oregon law shall apply to all disputes.

**7. RISKS AND BENEFITS:** By signing below, I agree that I have received an explanation of how the video and audio technology will be used to conduct the telemedicine health service, and I understand there are limitations to the technology and the process of telemedicine, including the potential for incomplete exchange or loss of information. Other possible risks include but are not limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider. Diagnoses could be inappropriately evaluated due to the inability to perform a physical exam.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Rarely, security protocols could fail, causing a breach of privacy of personal medical information.
- Very rarely, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgement errors.

I understand and consent to participate in and be videotaped and recorded during the telemedicine health service. I understand the written information provided above, and I hereby voluntarily and freely agree and give my consent to take part in the telemedicine health service and to any related evaluation, assessment, and diagnosis as the consulting health care provider deems appropriate for my current medical condition and the consultation.

Signature: _____ Date _____

If signed by other than patient, indicate relationship: _____

I refuse to participate in a telemedicine health service for the procedure(s) described above.

Signature: _____ Date _____

If signed by other than patient, indicate relationship: _____