Family First Medicine, APMC
902 S. Vienna Street
Ruston, LA 71270

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer questions that I consider to be inappropriate or am unwilling to have heard by other persons.

I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis, and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers.

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes. **DECLINE** _____ (initials of patient)

FOR DEMONSTATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation. **DECLINE** _____ (initial of patient)

Signature of patient (or parent/guardian):_____Date:_____

Please print the above name: _____

Signature of witness:_____

For withdrawal from telemedicine evaluation, please complete the following. I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): _____Date: _____

Signature of witness: _____