Telemedicine Session
Patient Authorization and Consent Form

Patient Name: _____ Date of Birth: _____ MRN: _____

1. **PURPOSE**: The purpose of this form is to obtain your consent in a telemedicine consultation in connection with your scheduled appointment.
2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
    - The provider may talk to you about your health history, exams, x-rays, and other tests. Other providers may take part in this discussion.
    - A visual and/or partial physical exam may take place. This may happen by video, audio, and/or or with other technology tools. A nurse or other healthcare staff may be in the room with you to help with the exam.
    - Non-medical staff may be in the room to help with the technology.
    - A report of the session will be placed in your medical record. You can get a copy from your provider.
3. **MEDICAL INFORMATION & RECORDS:** All laws about the privacy of your health information and medical records apply to telemedicine.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consulation, and all existing confidentiality protections under federal and North Carolina state law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in North Carolina, and that North Carolina law shall apply to all disputes.
7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered and you understand the written information provided above.

I agree to participation in a telemedicine consultation for the scheduled appointment.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness: _____

Witness written name: _____