

Hampton University Health Center

Notice of Privacy Practices/Informed Consent for Telemedicine Health via Zoom and/or Phone

Effective Date: July 22, 2020

This notice describes disclosure guidelines and information about telemedicine health treatment through Zoom and / or phone, how information about you may be disclosed, and how you can get access to this information. Please review this carefully.

Patient Name: _____ Address: _____ City: _____ State: _____	Date of Birth _____	Student Id Number _____
Healthcare Provider _____ Address: _____ City: _____ State: _____		Date Consent Discussed _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices as well as sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. Systems include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. resolution of images) to allow for appropriate medical decision making by the physician, nurse practitioner, physician assistant, and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgement errors.

Please initial after reading this page: _____

Scheduling Policy

With the exception of emergency situations, services at the Hampton University Health Center are provided on an appointment basis. Appointments typically last between 30-50 minutes. Depending on state law restrictions, appointments may be 15 minutes in nature. Thus, missed and cancelled appointments prevent valuable limited slots from being offered to other patients.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identified me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw or contest my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. The physician, nurse practitioner, or physician assistant explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician, nurse practitioner, physician assistant, or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (Name of Provider) to use telemedicine in the course of my diagnosis and treatment.

Signature of patient (or person
Authorized to sign for patient): _____ Date: _____

If authorized signer,
Relationship to patient: _____

Providers Signature: _____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____