TELEMEDICINE PATIENT CONSENT FORM

PATIENT NAME:_____

DATE OF BIRTH:_____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) or service(s).....New or Return Consultation with Dr. Michelle K. Jackson
2. **NATURE OF TELEMEDICNE CONSULT:** During the Telemedicine consultation a. Details of your medical histories, examinations, x-rays, and test results will be discussed with Dr. Jackson through the use of interactive audio (phone) or other telecommunical technology such as interactive HIPPA compliant GoTo Meeting platforms. b. A physical examination of you may take place.
3. **MEDICAL INFORMATION AND RECORDS:** All existing laws regarding your access to information and copies of your medical records apply to this telemedicine consultation.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have efforts have been made to eliminate confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state Oregon law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to a telemedicine consultation at any time without affecting your right to future care or treatment.
6. **RISKS, CONSEQUENCES AND BENEFITS:** Possible risks if a telemedicine consultation include, but are not limited to: information transmitted may not be sufficient to allow for appropriate decision making by Dr. Jackson. Delays in evaluation and treatment may be due to failure of equipment. In very rare instances, security protocols could fail, causing a breech of privacy of personal medical information. Expected benefits include improved access to medical care by enabling the patient to remain in a distant location. You have been advised of risks, benefits and consequences of telemedicine. You have the right to ask questions about the information presented to you in this form.

At the time of the consult, I will be physically present in the State of Oregon and I agree to participate in a phone or telemedicine consultation as described above:

Signature:_____

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

Date:_____**Time:**_____