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Please complete this form in black ink, sign and return to Carmen Roman, M.D. by mail or fax.

Patient Name: ____

CONSENT TO TELEMEDICINE CONSULTATION

1. PURPOSE. The purpose of this form is to obtain your consent for telemedicine interviews to facilitate diagnosis and on-going medical treatment.

2. NATURE OF TELEMEDICINE CONSULTATION. Telemedicine involves the use of audio and visual communications for your healthcare provider to interact with you to elicit medical information for the purpose of diagnosis and treatment. During telemedicine interviews, your healthcare provider will discuss your medical history and personal health information using interactive audio, visual and telecommunications technology.

3. BENEFITS OF TELEMEDICINE. Telemedicine allows contact with your healthcare provider in lieu of a traditional in-person office visit. Telemedicine is useful when a face-to-face meeting is inadvisable, inconvenient, or impossible.

4. RISKS OF TELEMEDICINE. Telemedicine depends upon telecommunication equipment and systems. Technical problems may arise that negate or diminish the value of a telemedicine interview. Lacking the privacy of the doctor's exam room, the patient will need to choose a physical space that protects their privacy during a session.

5. CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during a telemedicine consultation.

My doctor has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to telemedicine consultations.

Signature of Patient: ____________________________________ Date: ____/____/________

Signature of Parent for minors: ____________________________ Date: ____/____/________