Cartersville Pediatric Associates
958a Joe Frank Harris Parkway
Suites 101 & 105
Cartersville, GA 30120
Phone:(770)386-3011
Fax: (770)386-9451

Telemedicine Consent/Refusal Form

Patient Name: _____

DOB: _____

1. **PURPOSE**: The purpose of this form is to obtain your consent for you or your child to participate in the following telemedicine consultation in connections with the following procedures: **Non-emergent office consultaions**

2. **NATURE OF TELEMEDICINE CONSULT VISIT**: During the telemedicine consultation visit:

   a. Details of you or your child's medical history, examinations, x-ray, and test will be discussed if applicable with other health professionals using interactive video, audio, and telecommunication technology.
   b. A physical examination of you or your child may take place.
   c. A non-medical technician may be present in the telemedicine studio if any aid in the video transmission is needed.
   d. Video, audio, and/or photo recordings may be taken of you during the procedure or service(s)

3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation visit. Please note not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telemedicine consultation visit, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consult visit.

5. **RIGHTS**: You may withhold or withdraw consent to the telemedicine 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 visit will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES, AND BENEFITS**: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your healthcare 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 visit. All your questions have been answered and you understand the written information provided above.

I **AGREE to participate in telemedicine consultations/visits for the procedure(s) described above.

Signature: _____

I **REFUSE to participate in a telemedicine consultation/visits for the procedures described above.

Signature: _____

If signed by someone other than the Patient, indicate relationship: _____
Date: _____ Time: _____

Witness: _____
Date: _____ Time: _____