Longs Peak Family Practice, P.C.
Informed Consent for Telemedicine Services and Treatment

Name of Patient:	
Date of Birth:	
Address:	

I understand how a telemedicine encounter is different from an in-person consultation due to the fact that I will not be in the same room as my healthcare provider, and how this can improve my access to care, including limiting the spread of communicable diseases including COVID-19. At the same time, I also understand that telemedicine has certain risks including a limited physical exam and time constraints. I understand these risks and limitations and will have the opportunity to discuss these with my doctor at the time of my consultation.

I also understand that there may be interruptions, unauthorized access and technical difficulties associated with my telemedicine encounter. Because of these reasons and the fact that a telemedicine consultation may not be appropriate to address my medical situation, my healthcare provider or I can discontinue the telemedicine consult.

I also understand that I have the right to refuse or stop participation in telemedicine services at any time and that it will not affect my right to future care or treatment.

I understand that all confidentiality protections required by law will apply to my care but recognize that my healthcare information may be shared with other individuals and entities for the purposes of providing continuity of care, billing and internal operations.

I understand that during the COVID-19 Pandemic, security measures may be lessened in accordance with the U. S. Department of Health and Human Services (HHS) to ensure improved access to care.

I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information.

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.

If an emergency occurs during a telemedicine encounter when I am at a non-health-care site, I will call 911 and maintain the telemedicine encounter (if possible) until help arrives.

By signing this form, I certify:

That I have read or had this form read and/or explained to me.

That I fully understand its contents including the risks and benefits of a telemedicine encounter.

That I have been given ample opportunity to asks questions and that any questions have been answered to my satisfaction and that I have been offered a copy of this Informed Consent Form.

Signature of Patient (or person authorized to sign for patient)

_____ *Date:* _____

***If authorized signer, relationship to patient:* _____**