

## Telemedicine Patient Consent Form

**Please note: In order to participate you must be using an Android or Apple phone or Firefox or Chrome Web browser.**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I, (name of patient or parent/guardian) \_\_\_\_\_, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical health care.

\_\_\_\_\_ I understand that I can withdraw my permission at any time and I do not have to answer any questions I consider to be inappropriate, or am unwilling to have heard by other persons.

\_\_\_\_\_ I understand that with any technology, telemedicine does have its limitations. There is no guarantee, therefore, this telemedicine session will eliminate the need for me to see a specialist in person.

\_\_\_\_\_ I understand that medical records of telemedicine services will be kept at University of the Pacific Hearing and Balance Center.

\_\_\_\_\_ I understand that my personal health information will not be recorded or data stored by CounselEar or other manufacturer telemedicine sites.

\_\_\_\_\_ I understand that CounselEar and other manufacturer telemedicine sites we might use are HIPAA compliant.

Signature of Patient (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ **I wish to decline telehealth consultations at this time.**

Signature of Patient (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_