UNIVERSITY OF THE
PACIFIC
Hearing and
Balance Center

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 healthcare.

_______ 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 if I do not choose to participate in a telemedicine session, no action will be taken against me, which will cause a delay in my care, and I may still pursue a face-to-face consultation.

_______ 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: ______________________________