**Telemedicine consent form**

* I authorize Dr. Emerlita Manguiat to provide me with their observations and recommendations regarding my medical condition and potential courses of action, using telemedicine. The use of telemedicine involves the electronic communication of my medical information. I understand that Dr. Manguiat will not perform an in-person physical examination during the telemedicine consult. She will rely solely on the information telecommunicated. I authorize Dr. Manguiat to consult with any other physician specialists whom they may choose to involve in my case if necessary.
* I understand that I have the following rights with respect to the telemedicine services performed:
	1. Right to withdraw. I have the right to withhold or withdraw my consent to telemedicine at any time, without affecting my future right to health care or treatment and without risking the loss of my health coverage.
	2. Access to information. I have the right to inspect all medical information transmitted during the telemedicine consultation and may receive copies of this information for a reasonable fee.
	3. Confidentiality. The laws that protect the confidentiality of medical information apply to telemedicine, and no information or images from the telemedicine interaction which identifies me will be disclosed to other parties without my consent, except as permitted by law.
* I understand that there are risks from telemedicine, including but not limited to: loss of records from a failure of electronic equipment; power failure with loss of communication; and invasion of electronic records from outsiders (hackers). In addition, signs and symptoms that might be detected during an in-person physical examination may not be detected through telemedicine. I understand during the course of the telemedicine consult, the doctor may decide that a physical exam is needed for which an appointment will be needed.
* I warrant that Dr. Manguiat’s observations and recommendations are limited in scope and nature to the specific issues discussed during the telemedicine consult.
* I have read and understand the information provided above. I agree and all my questions have been answered to my satisfaction. I consent to receive the telemedicine services described above.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_