TELEMEDICINE INFORMED CONSENT

I, _____, agree to participate in the Little Rock Allergy and Asthma Clinic Telemedicine Clinic. I understand that my image and my Protected Health Information will be transmitted electronically through the videoconference to physicians, healthcare professionals, and to personnel authorized to receive such information for the purpose of providing medical diagnostic assessment and treatment services to me.

I understand that the transmissions are encrypted and the likelihood of this transmission being intercepted by unauthorized persons is extremely small but is a possibility. I understand the any Telemedicine session might be recorded and that any recording might be used for data collection, research, and educational purposes. I understand that if such recordings are used for these purposes, my personal image will not be disclosed and effort will be made to protect other identifying information from disclosure.

I understand that I can withdraw my permission for the videoconference any time prior to the videoconference. I also understand that I may interrupt the videoconference at any time. Withdrawing my consent or interrupting the videoconference will not have any negative impact on my ability to continue my care with Little Rock Allergy and Asthma Clinic and I understand that I may still pursue a consultation in person with a physician or other healthcare personnel. I understand if I interrupt the videoconference, the videoconference will be incomplete and the healthcare professionals involved in the videoconference will be unable to provide treatment or services to me at that time.

I understand that there are limits to Telemedicine technology and there is no guarantee that this Telemedicine session will eliminate the need for me to see a specialist in person in order to receive appropriate or additional treatment for my current condition.

I have read this document carefully and any questions I have asked about this consent have been answered to my satisfaction. I fully understand the terms of my consent, to the release of Protected Health Information and to participate in Little Rock Allergy and Asthma Clinic Telemedicine videoconference(s).

*I understand my co-pay must be paid one week prior to the appointment.

*I understand that no skin testing or breathing test can be done by telemedicine.

*I understand that I must have a device that can use video and audio.

* I will receive an email showing how to connect a few minutes before my appointment.

*My appointment will last a maximum of 15 minutes.

_____ _____

Signature of Patient or Legal Representative Date

If Legal Representative of Patient, print name: _____

State of Authority (parent, guardian, POA, other):_____

Witness:_____