

Patient Name: DOB:

Medical/TDCJ #: Provider Name: Telemedicine site:

# Informed Consent to Telemedicine/Telepharmacy Consultation

I have been asked by my healthcare provider to take part in a telemedicine/telepharmacy consultation with Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine/telepharmacy consult is done through a two-way audio/video link-up whereby the physician or other health provider at TTUHSC El Paso can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The TTUHSC El Paso and affiliated telemedicine/telepharmacy consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this technology. These include but are not limited to:
	* Interruption of the audio/video link.
	* Disconnection of the audio/video link
	* A picture that is not clear enough to meet the needs of the consultation
	* Electronic tampering.

If any of these risks occur, the procedure might need to be stopped.

1. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
2. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
3. I will not receive any royalties or other compensation for taking part in this telemedicine/telepharmacy consult or associated with any use by TTUHSC El Paso.
4. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
5. Reasonable and appropriate efforts has been made to eliminate any confidentiality risks associated with telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation
6. I understand that the telemedicine consultation will be paid by me or my insurance.
7. I understand I can make a complaint of my provider to the Texas Medical Board by going online at <http://www.tmb.state.tx.us/page/place-a-complaint>or calling the Complaint Hotline at 800-201-9353.
8. I understand and agree for the healthcare providers to text message or email information to me related to the telemedicine visit.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as “agree” and I do not agree to any that I have initialed as “decline.”

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize TTUHSC El Paso and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

# Date: Time: am/pm

**Signature: Printed Name:**

**Witness: Interpreter (if applicable):**

Revised January, 2021