



CASTLE FAMILY HEALTH CENTERS

Authorization and Consent to Participate in Telemedicine Consultation

Patient Name: _____ MC# _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedures: _____

2. **NATURE OF DIGITAL IMAGING CONSULTATION:** During the telemedicine consultation:
 - a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of digital images and e-mail.
 - b. Physical examination may take place.
 - c. Video and/or photo recordings may be taken of the procedure(s).
3. **MEDICAL INFORMATION AND RECORDS.** All existing laws regarding your access to medical information and copies of your medical records apply to this digital imaging consultation. Additionally, dissemination of any patient identifiable images or other information from this digital imaging interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the digital imaging consultation, and all existing confidentiality protections under federal and California law apply to information disclosed during this digital imaging consultation.
5. **RIGHTS.** You may withhold or withdraw consent to the digital imaging consultation at any time before or during the consultation without affecting the right to future care or treatment, or risking the loss or withdrawal of any program benefit to which you would otherwise be entitled. You may also withdraw consent to extra personnel participating in the digital imaging consultation.
6. **DISPUTES.** I agree that any disputes I may have with any medical provider not employed by Castle Family Health Centers arising from this digital imaging consultation will be resolved in California and that California law shall apply to any such disputes. I further agree that any disputes I may have with Castle Family Health Centers arising from this digital imaging consultation will be resolved in accordance with corporate policies and other means as allowed under the Federal Tort Claims Act.
7. **RISKS, CONSEQUENCES, AND BENEFITS.** I have been advised to all the potential risks, consequences and benefits of digital imaging. My health care practitioner has discussed with me the information and all my questions have been answered. I understand the written information provided above.

Signature: _____

Patient or patient's legal representative

Date: _____