CONSENT TO PARTICIPATE:

I have been asked to participate as a client on the _____ telemedicine network. I will be receiving health care services through interactive video and/or camera equipment. I understand the use of video/camera equipment is a new method of health care delivery. I understand that, at this time, there are no known risks involved with receiving my care in this way. I understand the equipment will be shown to me and I will get to see how it works before I receive any services. I understand my participation in this is totally voluntary and I may decide to quit at anytime. My privacy and confidentiality will be protected at all times. When I am receiving services over the video, I can see who is in the room at the other site.

I give my consent to receive services over the videoconferencing and/or camera equipment. I understand the services I receive will become part of my treatment record. I understand the health care providers at both sites will have access to any relevant medical information about me including any mental health records, psychiatric and/or psychological information, alcohol and/or drug abuse, communicable or venereal disease, and other sensitive information. I have read this document and I hereby consent to participate in telemedicine network under the terms described above. I understand this document will become a part of my medical record.

_____ _____
Printed Name of Patient Clinic Location

_____ _____
Signature of Patient or Legal Representative Date

Capacity (Relationship) of Legal Representative (if applicable)*: _____

*May be requested to provide verification of representative status.

_____ _____
Signature of Witness Date