ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

CONSENT TO PARTICIPATE IN TELEMEDICINE HEALTH SERVICES

Local Hospital Name: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine health service provided by Oregon Health & Science University in connection with the following services or procedure(s) provided

2. **NATURE OF TELEMEDICINE HEALTH SERVICE:** During the telemedicine health service:
   a. Details of your medical history, examinations, x-rays, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
   b. Visual and physical examination of you may take place.
   c. Nonmedical technical personnel may be requested to enter the area where telemedicine is being performed.
   d. Video, audio, and/or photo recordings may be taken of the encounter(s).

3. **MEDICAL INFORMATION AND RECORDS:** All existing laws regarding privacy and security of your health information and copies of your medical records apply to this telemedicine health service and the audio and video information transmitted, received and stored electronically as part of this service. Any dissemination of patient-identifiable images or information from this telemedicine interaction to researchers or other entities for purposes other than your treatment, payment for healthcare services you receive, and certain necessary administrative and operational activities supporting your care shall not occur without your authorization.

I acknowledge that I have been provided a Notice of Privacy Practices by OHSU _____ (initial)

I understand the resulting video images and audio recordings of me may be captured and stored electronically at OHSU. I understand that these recordings may be later viewed and used for purposes of evaluation and training at OHSU which may include OHSU non-physician personnel and students. I understand and consent to the use of these images and audio recordings for the telemedicine consultation and, potentially, evaluation, education and training.

4. **OHSU CONDITIONS OF TELEMEDICINE SERVICE:** OHSU is a teaching institution. By signing this Consent form, the patient or the patient's representative acknowledges, understands and agrees that residents, interns, medical students, students of ancillary health care professions (i.e., nursing, x-ray, rehabilitation therapy) and post-graduate fellows may examine, treat and participate in telemedicine health services, under the supervision of the attending physician, as part of the medical education program of the institution.

5. **RIGHTS:** You may withhold or withdraw your consent to the telemedicine health service at any time before or during the consult without affecting the right to future care or treatment. You may also withdraw consent to extra personnel participating in telemedicine health services. You may also revoke your consent to allow OHSU to store and use the video images and audio recordings. The request to revoke consent must be in writing and received by OHSU. If you revoke your consent, the video images and audio recordings will be

destroyed and no longer used by OHSU. Any uses of the video made with your permission prior to OHSU's receipt of your revocation cannot be changed or undone. To revoke your consent to OHSU's storage and use of video images and audio recordings of your telemedicine health service, please send a written statement to:

Clinical Outreach Department
Oregon Health & Science University
3181 SW Sam Jackson Park Rd (MC: CR9-6)
Portland, OR 97239

and state that you are revoking your consent for OHSU to store and use video images and audio recordings of your telemedicine health service.

6. **DISPUTES:** I agree that any dispute arriving from the telemedicine consult will be resolved in Oregon, and that Oregon law shall apply to all disputes.

7. **RISKS AND BENEFITS:** By signing below, I agree that I have received an explanation of how the video and audio technology will be used to conduct the telemedicine health service, and I understand there are limitations to the technology and the process of telemedicine, including the potential for incomplete exchange or loss of information. I understand and consent to participate in and be videotaped and recorded during the telemedicine health service. I understand the written information provided above, and I hereby voluntarily and freely agree and give my consent to take part in the telemedicine health service and to any related evaluation, assessment, and diagnosis as the consulting health care provider deems appropriate for my current medical condition and the consultation.

_____ / / : ☐ am ☐ pm
Signature of patient (or patient's legal representative — Date — Time

I refuse to participate in a telemedicine health service for the procedure(s) described above.

_____ / / : ☐ am ☐pm
Signature — Date — Time

_____ / / : ☐ am ☐ pm
If signed by other than patient, indicate relationship: — Date — Time

_____ / / : ☐ am ☐ pm
Witness — Date — Time