Rio Grande Internal Medicine, PC
Dr. Kevin Goodluck
Informed Consent for Telemedicine Services

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________ DATE: ____________

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Rio Grande Internal Medicine, PC providing health care services to me via telemedicine.

NATURE OF TELEMEDICINE CONSULT: During telemedicine consultation:

1. Details of your medical history, examinations, x-rays, and test may be discussed using interactive video, audio and telecommunication technology.
2. A physical examination of you may take place.
3. A non-medical technician or Medical Assistant may be present in the telemedicine studio to aid in the video transmission or assist physician.

MEDICAL INFORMATIN AND RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, telecommunications are <u>not</u> recorded and stored. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand my insurance carrier will have access to my medical records for quality review/audit.

CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and New Mexico state law apply to information disclosed during this telemedicine consultation.

DISUPTES: You agree that any dispute arriving from the telemedicine consult will be resolved in New Mexico, and that New Mexico law shall apply to all disputes.

RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

COPAYS, COINSURNANCES, DEDUCTIBLES: I understand that I will be responsible for any copayments, coinsurances and/or deductibles that apply to my telemedicine visit.

I understand that I have the right or my Medical Power of Attorney (MPOA) has the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment. I or my MPOA may revoke my consent orally or in writing at any time by contacting Rio Grande Internal Medicine, PC at 505-385-9459. If this consent is in force (has not been revoked) Rio Grande Internal Medicine, PC may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient): __________________________________
Date: _________________

If authorized signer, relationship to patient:
Witness: ____
Date: ___________________

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