EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE CONSENT REVIEWED AND AGREED TO PROCEED: _____

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, follow-up and/or education, and may include any of the following: patient medical records, medical images, live two-way audio and video, output data from medical devices and sound and video files. Electronic systems will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine that identifies me will be disclosed without my consent.

I understand that I have 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 understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated and all of my questions have been answered to my satisfaction.

I hereby authorize Ear, Nose and Throat Specialists of Northern Virginia to use telemedicine during my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____

Date: _____

If authorized signer, relationship to patient: _____