CSUDH
CALIFORNIA STATE UNIVERSITY, DOMINGUEZ HILLS

Student I.D #:_____

Phone #: _____

Telemedicine Informed Consent Form

I _____ (print your name) hereby consent to engaging in telemedicine with clinical staff at the CSUDH SHC (Student Health Center), as part of my medical care. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in California.

I understand that I have the following rights with respect to telemedicine:
1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; also this will not put me at risk for loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. Laws that protect the confidentiality of my medical information also apply to telemedicine. As such, the information disclosed by me during the course of my treatment is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse.

3. The dissemination of any personally identifiable images or information from telemedicine interaction to researchers or other entities shall not occur without my written consent.

4. There are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my medical providers that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. Telehealth is relatively new, and therefore lacks research indicating that it is an effective means of receiving care. I understand that telemedicine-based services and care may not be as complete as face-to-face services. Telehealth may lack visual and/or audio cues, which may increase the likelihood of misunderstanding each other. Furthermore, it does not allow for a hands-on physical examination, which could lead to unintended omissions in diagnostic consideration. I also understand that if my medical provider believes I would be better served by another form of medical services (e.g. face-to-face services) I will be referred to a medical facility that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of medical care, and that despite my efforts and the efforts of my medical provider, my condition may not improve, and in some cases may even get worse. I agree to use a video-conferencing platform, if needed, for our virtual sessions, and the provider will explain how to access it.

6. If I am ever experiencing an emergency, including a mental health crisis, I will call 911 or go my nearest emergency room.

7. I have a right to access my medical information and copies of medical records in accordance with California Law.

By signing this agreement I acknowledge that I understand and agree to the following:

- I must inform my provider of my exact location during the telehealth appointment, and inform them if this location changes.
- I must identify a person who can be contacted in the event that my provider believes my safety is at risk.
- My provider may need to verify that my emergency contact person is able and willing to go to your location in the event of an emergency, and/or call 911 or transport me to a hospital if my provider deems necessary.
- I will engage in appointments only when I am physically in California. My provider will confirm this each session.
- I will engage in appointments only from a private location where I will not be overheard or interrupted.
- I will use my own computer or device, that is not publicly accessible and ensure that the computer or device I am using has updated operating and anti-virus software.
- I will not record any appointments, nor will the SHC record my session without my written consent.

I may contact my healthcare provider at (310) 243-3629, for any questions I have related to the medical services received through the telehealth provider**. I have read and understand the information provided above and have been given the opportunity to discuss it with my provider to have all my questions answered to my satisfaction.**

_____

Patient Signature Email Address Date