WILLIAM PATERSON UNIVERSITY

COUNSELING, HEALTH & WELLNESS CENTER

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

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1) **Purpose and Benefits.** The purpose of this form is to obtain consent to participate in telemedicine consultation to enable patients to get real-time access to a healthcare provider with the convenience of using a video chat on a smart phone, tablet, or computer.

2) **Nature of Telemedicine Consultation**: During the telemedicine consultation:
   a) Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination may take place.
   c) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and New Jersey State law apply to information disclosed during this telemedicine consultation.

5) **Risks and Consequences.** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a healthcare provider at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to provider contact. Following the telemedicine consultation, your provider may recommend an in-person office visit or a local emergency room for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the healthcare provider if you travel health center location within the office hours.

7) **Financial Agreement.** You have read and signed the Acknowledgment of Financial Responsibility and Insurance Authorization Consent Form which applies to telemedicine consultation.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above. I hereby give my informed consent for the use of telemedicine in my medical care.

Print Student Name:_____

Student ID # 855:_____

Student Signature:_____

Date:_____

Parent/Guardian Signature _____

(*Required only if the student is 17 years old or younger)*