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TELEMEDICINE PROGRAM
TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine therapy session. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by Mrs. Crane (and/other persons involved in my medical or mental health care.) [**Note:** The likelihood of this transmission being intercepted by persons other than Mrs. Crane is extremely small]. I understand that with this document I am also giving general consent to receive treatment from Mrs. Crane.

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or that I am unwilling to be heard by Mrs. Crane. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept secure by Mrs. Crane.

Signature of Client:

X

Signature of witness: _____ Date: _____

- *For withdrawal from a telemedicine evaluation, please complete the information below.*

- **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).** I have chosen not to participate further in this telemedicine therapy.

Signature of patient (or parent/guardian): _____ Date: _____

Signature of witness: _____