CONSENT TO PARTICIPATE IN A
TELEMEDICINE CONSULTATION/TREATMENT

1. I ______________________________ [print name of parent], authorize and voluntarily consent to the participation and treatment of ______________________ [print name of patient] in a Telemedicine Consultation and/or treatment with the Children’s National Medical Center.

2. I understand that as a participating patient, my physician and I will communicate by interactive television (videoconferencing) with physicians and health care professionals at Children’s National Medical Center. I understand that medicine is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examinations and treatments.

3. It has been explained to me how the video conferencing technology will be used to conduct a visit. I understand that this visit will not be the same as an in-person visit due to the fact that my child will not be in the same room as the healthcare provider at the distant site. I also understand that I have the option to see a physician in person, if I chose.

4. I further understand that there are potential risks to telemedicine, including but not limited to, interruptions, unauthorized access and technical difficulties. I understand that either the healthcare provider or I can discontinue my child’s telemedicine health visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand it may be necessary for others to be present during the visit other than my child’s healthcare team and provider in order to operate the video equipment. These individuals are bound to maintain confidentiality of all information obtained. I further understand that I have the right to request the following when nonmedical personnel are present to: (1) omit specific details of my child’s medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the examination room; and/or (3) terminate the visit at any time.

6. During my child’s telemedicine visit, I understand that the responsibility of the telemedicine healthcare provider concludes upon the termination of the video conference connection and the Medical Center is not responsible for the actions of the distant site.

7. Any interview, tape, film or photograph made of my child will be used for medical purposes and maintained by the Children’s National Medical Center as confidential medical records, consistent with Federal and State law.

8. By signing this consent, I authorize my physician to release any relevant medical information, pertaining to my child’s medical condition and medical care to Children’s National Medical Center, its physicians and healthcare professionals. I also authorize the Medical Center, or its physicians, to release any and all information to my insurance company or any other agent that may be responsible for paying my medical bills. I
further understand and consent to being interviewed, taped, filmed, or photographed by my physician and/or the Children’s National Medical Center.

9. I understand that I have the right to withdraw my consent at any time. If at any time I am not satisfied with the services rendered, I may file a complaint with the Children’s Ombudsman team.

10. I have read (or have had read to me) this document carefully, and hereby consent to participate in the Telemedicine consultation/services under the terms described above.

This consent is given on behalf of ___________________________ [print name of patient] because the patient is a minor or has been determined to be incompetent to give medical consent.

______________________________   ________________________  _____
Signature of Parent/Legal Guardian       Relationship to Patient       Date

______________________________   ________________________  _____
Witness’ Signature                   Print Witness’ Name            Date