PRINT RESET

De Anza College Student Health Services
21250 Stevens Creek Blvd. Cupertino, CA 95014
Phone: (408) 864-8732 Fax: (408) 864-8983

INFORMED CONSENT FOR VIRTUAL VISIT SERVICES

Patient Name:		Date of Birth:		SID#:
Patient Address:	City:	State:	Zip:	Date Consent Discussed:

PURPOSE:

The purpose of this form is to obtain your consent to participate in a virtual visit consultation in connection with the basic health care services provided by the De Anza College Student Health Services.

Virtual Visit Services/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. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, 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 used 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 and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the providers obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of virtual visit services/telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the providers and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

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INFORMED CONSENT FOR VIRTUAL VISIT SERVICES

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to virtual visit services/telemedicine, and that no information obtained in the use of virtual visit services/ telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of virtual visit services/telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of virtual visit services/telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. The De Anza College Student Health Services has explained the alternatives to my satisfaction,
5. I understand that virtual visit services/ telemedicine may involve electronic communication of my personal medical information to other providers who may be located in other areas, including out of state.
6. I understand that it is my duty to inform the De Anza College Student Health Services of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of virtual visit services/telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all virtual visit encounters with the De Anza College Student Health Services.

PATIENT CONSENT TO THE USE OF VIRTUAL VISIT SERVICES

I have read and understand the information provided above regarding virtual visit services/telemedicine, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize De Anza Student Health Services to use virtual visit services/telemedicine in the course of my consultation, diagnosis and treatment.

PATIENT'S SIGNATURE (OR AUTHORIZED PERSON TO SIGN FOR PATIENT) **DATE**

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT **DATE**

WITNESS **DATE**

I have been offered a copy of this consent form. _____ (Patient's Initials)