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(864) 888-4464
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BLUE RIDGE PEDIATRICS
Professional, Personalized Care for Newborns, Children & Adolescents

NORTH PARK OFFICE PARK
457-B HWY 123 BYPASS
SENECA, SC 29678

Blue Ridge Pediatrics
Telehealth Consent Form

1. PURPOSE: The purpose of this form is to obtain your consent for a telehealth visit with a provider.

2. NATURE OF TELEHEALTH VISITS: Telehealth involves the use of audio, video or other electronic communications to interact with you, and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education.

3. RISKS, BENEFITS AND ALTERNATIVES: The benefits of telehealth include having access to your provider at times when if may be unsafe or when you are unable to travel to their location. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the virtual appointment. Additionally, in rare circumstances, security protocols could fail, causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a provider.

5. MEDICAL INFORMATION AND RECORDS: All laws concerning patient access to medical records and copies of medical records apply to telehealth. Dissemination of any patient identifiable images or information from the virtual visit to researchers or other entities shall not occur without your consent.

6. CONFIDENTIALITY: All existing confidentiality protections under federal and South Carolina law apply to information used or disclosed during your virtual visit.

7. RIGHTS: You may withhold or withdraw your consent to a telehealth visit at any time before and/or during the visit without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

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Patient Name: _____ DOB: _____

I have read the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agree to telehealth visits.

_____
Signature of Patient or Patient's Representative

_____
Date

_____
Relationship of Representative to Patient

REFUSAL: I refuse to participate in a telemedicine consultation as described above.

_____
Signature