 SOUTH TEXAS MENTAL HEALTH ASSOCIATES

Informed Consent to Telemedicine Consultation

I have been asked by my healthcare provider to take part in a telemedicine consultation with South Texas Mental Health Associates and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult is done through a two-way video link-up whereby the physician or other

health provider at STMHA can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The STMHA and affiliated telemedicine/telepharmacy consultants can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

If any of these risks occur, the procedure might need to be stopped.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as

“agree” and I do not agree to any that I have initialed as “decline.”

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize TTUHSC and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____
Signature:_____ Witness: _____

Time:_____ am/pm
Printed Name:_____ Interpreter (if applicable):_____