PATIENT: _____ DOB:_____ PHONE:_____
DATE: _____ TIME: _____

Telemedicine Consent

I authorize Dr. Gann's Diet of Hope Institute to utilize telemedicine technologies in determining my diagnosis and/or treatment. I understand telemedicine means the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occurs in the physical presence of the patient.

Dr. Gann's Diet of Hope Institute 50 E Croydon Park Rd. Tucson, AZ 85704 (520)696-3438 will be consulted through audio, video or data imaging and communications.

Benefits

The reason telemedicine is being utilized is for the following reason(s):

- Convenience of encounter for the patient.
- Access to healthcare technology not physically readily available.
- Need for expertise from a consultant not readily available.
- Other_____

Risks

The reasonably foreseeable risks of utilizing telemedicine technologies may include:

- Audio or visual images may not be as good as in person.
- Telemedicine physician cannot utilize the senses of touch and smell to assist in diagnosis, treatment or therapy.
- Other_____

Alternatives

- The possible alternatives may be:
- Travel distance to physically see consultant or undergo the testing/procedure.
- Undergo therapy available locally which may not produce desired result.
- Other_____

Confidentiality

I understand every reasonable effort will be made to protect the security and confidentiality of my medical information which is copied and forwarded to the above named consulting physician either through the mail or transmitted through electronic means as part of telemedicine.

Option Not to Participate

I understand I have the option of not participating in telemedicine and can withdraw from participation in utilizing telemedicine technology in my diagnosis or treatment at any time by expressing this to my physician.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

_____ _____
PATIENT | LEGAL REPRESENTATIVE DATE TIME (AM|PM)

_____ _____
WITNESS'S SIGNATURE DATE TIME (AM|PM)