Pulmonary & Sleep Physicians Of Houston P.A
501 Orchard St. #200
Webster, TX 77598

Telemedicine Consent Form

I wish to have a telemedicine consultation with my healthcare provider _____ (provider's name). This means that I will, through interactive video connection, be able to consult with the above named physician about my condition.

My healthcare provider has explained to me how the telemedicine technology will be used to do such a consultation.

I understand there are potential risks with this technology:

1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. I may be required to go to the location of the consulting physician if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis.

The benefits of a telemedicine consultation are:

1. You may not need to travel to the location.
2. You have access to a specialist through this consultation.

I give my consent to be interviewed by the health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I understand that a limited physical examination will take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time.

I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers including my primary care physician who may need this information for continuing care purposes.

I hereby release Pulmonary & Sleep Physicians P.A, its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.
I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby

consent to participate in the telemedicine visit under the conditions described in the document.

_____ _____

Patient signature Date

Pulmonary & Sleep Physicians of Houston P.A

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