1. Telemedicine Consent and Acknowledgements

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me or my child will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my child's visit at any time without affecting their right to future care or treatment.
3. I also understand that if the provider believes my child would be better serviced by a traditional face –to-face encounter, they may, at any time stop the telemedicine visit and recommend a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed or assured.

Patient/Guardian Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and my questions have been answered to my satisfaction. I hereby give my informed consent to the use of telemedicine in my child's care.

Promissory Note and Authorization to Pay:

I authorize Penn Highlands Healthcare to release information to insurance carriers concerning my child's illness and treatments for the purpose of payment. I accept all payments for medical services rendered my child. I understand I am responsible for any amount not covered by my insurance including co-pays, deductibles, and non-covered services.

Patient Rights and Responsibilities:

I further acknowledge I have received a copy of Penn Highlands Healthcare's Notice of Privacy Practices.

I hereby authorize Penn Highlands Healthcare to use telemedicine in the course of my child's diagnosis and treatment.

Student Name: _____

Date of Birth (MM/DD/YYYY): _____

Signature of Parent/Guardian: _____

Printed Parent/Guardian Name: _____

Relationship to patient: _____ Date: _____

Signature of Patient (18-year old or emancipated minor): _____

Date: _____