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with MUSC Health

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Last Name

First Name

Middle Initial

Date of Birth

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## Televisit Patient Consent

**Purpose:** The purpose of this form is to obtain your consent to participate in a televisit consultation in connection with the following procedures and/or services.

**Nature of the Televisit Consult:**

- Details of your medical history, examinations, x-rays, and tests will be discussed through interactive video, audio, and telecommunication technology.
- A physical examination may take place.
- Video, audio, and/or photo recordings may be taken of you during the procedure or service.

**Medical Information and Records:** All existing laws regarding your access to medical information and copies of your medical records still apply to this televisit consultation. Please note not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this televisit interaction to researchers or other entities shall not occur without your consent.

**Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the televisit consultation, and all existing confidentiality protections under federal and South Carolina state law apply to information disclosed during this televisit consultation. Rights: You may withhold or withdraw consent to the televisit consultation at any time 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.

**Disputes:** You agree that any dispute arising from the televisit consult will be resolved in South Carolina, and that SC law shall apply to all disputes.

**Risks, Consequences and Benefits:** You have been advised of all of the potential risks, consequences, and benefits of televisit. Your health care provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the televisit consultation. All your questions have been answered, and you understand the written information provided above.

**Consent:**

- I agree to participate in a televisit consultation for the procedures prescribed above
- I refuse televisit consultations

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Signature of Patient/Legal Representative

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Date

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Print Name of Patient/Legal Representative

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Relationship to Patient