CRISTINA OCAMPO OD PLLC
THERAPEUTIC OPTOMETRIST
LICENSE#6696T
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Informed Consent for Telehealth Services

Date: _____

Patient Name: _____ DOB:_____

Telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. This information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video
- Output data from sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Quick access to medical care
- Fast and efficient medical evaluation and management.
- Obtaining expertise of a distant Optometrist

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases delays in medical evaluation and treatment could occur due to deficiencies or failures of the remote equipment
- In very rare instances, security protocols could fail, causing a breach of privacy

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My optometrist has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
6. I understand that it is my duty to inform my optometrist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my optometrist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Cristina Ocampo OD PLLC to use telemedicine in the course of my diagnosis and treatment.

Signature of patient:_____ Date:_____

(If minor parent/guardian signature)

If authorized signer, relationship to patient:_____

Date:_____