UPTOWN
ALLERGY & ASTHMA

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TELEMEDICINE INFORMED CONSENT

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with Uptown Allergy & Asthma.

2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
   a. Details of your medical history, examinations, imaging and past tests will be discussed with members of the Uptown Allergy & Asthma team through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination may take place

3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding access to medical information and copies of your medical records apply to this telemedicine consultation. Please note telecommunications are not recorded or stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with this telemedicine consultation, and all existing confidentiality protections under federal and Louisiana state law apply to information disclosed during this telemedicine consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine 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.

6. **RISKS, CONSEQUENCES & BENEFITS:** You understand all the potential risks, consequences, and benefits of telemedicine. You have had the opportunity to ask questions and the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information presented above.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to a telemedicine consultation.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

_____ _____
Printed Name and Signature of Witness Employee Job Title