TELEMEDICINE PATIENT CONSENT / REFUSAL FORM

PATIENT DETAILS	
PATIENT NAME: Ram Singh	DATE OF BIRTH: 18/12/1960
ADDRESS: 144, House on Mathura Gate Chennai, Pin code - 600010	

•**PURPOSE.** The purpose of this Consent Form is to obtain your consent to participation in telemedicine consultation in connection with the following procedure (s) and/ or service (s):S

[*insert details*] – HEADACHE

Symptom or Condition

•**NATURE OF CONSULT.** During the telemedicine consultation, the following may be sought or undertaken:

1. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunications technology.
2. Your physical examination may take place.
3. A non-medical technician may be present in the telemedicine center to aid in the video transmission.
4. Video, audio and/ or photo recordings may be taken of you during the consult.

Privacy Issues

•All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Note that dissemination of any identifiable images or information for this telemedicine interaction to other researchers or other entities shall not occur without your consent .

Confidentiality Issues

•Reasonable efforts have been made to eliminate any confidentiality risks associated with this telemedicine consultation.

•You may withdraw or withhold your 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 benefit to which you would otherwise be entitled.

Undertaking

I have been advised of all the potential risks, consequences and benefits of telemedicine. My registered medical practitioner has discussed with me the information cited above, and I have understood the terms of this telemedicine consultation.

I agree/ do not agree to participate in telemedicine consultations for the procedures/ s and or service /s discussed above.

Signature: _____

If signed by caregiver, indicate relationship: _____

Signature of Patient or Caregiver

RMP DETAILS	
RMP NAME : Kaml Jeet	RMP Registration No.: TNC-35621
Contact Details: 98 3321-67891	