PRIMARY CARE
ASSOCIATES, PC

Telemedicine / Audio Virtual Visit Patient Consent / Refusal Form

Patient Name: _____ Date of Birth: ___ / ___ / _____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in virtual, electronic, telephone, and or telemedicine visits for your medical conditions or wellness visit. Telemedicine visits may be necessary to provide medical care if the patient is unable to physically be present to the physician office.
2. **NATURE OF TELEMEDICINE VISIT**: The telemedicine or virtual visit may include:
    a. Review and discussion of your medical history, examinations, x-rays, discussions with other health professionals, and review or medications through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place with video access
    c. Video, audio and /or photo recordings may be taken of you during the service(s) and such photos may be maintained in your medical record.
3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding access to your medical record information and copies of your medical record apply to all telemedicine visits and consultations. Please be aware that most telecommunications are not recorded and stored. Some pictures may be kept as needed for your medical record. Dissemination of any patient identifiable images or information for this telemedicine interaction shall not be given to any entity without your consent.
4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine visit or consultation. All existing confidentiality protections under federal and state law apply to information disclosed during the telemedicine visit.
5. **RIGHTS**: You may withhold or withdraw consent to the telemedicine visit at any time without it affecting your right to future care or treatment, or risking the loss or withdrawal of any benefits to which you would otherwise be entitled.
6. **DISPUTES**: You agree that any dispute arriving from the telemedicine visit will be resolved in South Carolina and that South Carolina law will apply to all disputes
7. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all potential risks, consequences, and benefits of telemedicine. You are aware of the information above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine visit. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine visit for the services described above.

Patient / Guardian Signature: _____

If other than patient then indicate relationship : _____

Date: ___/ ___ / _____ Time: _____ Witness: _____

Sign only if you DO NOT WISH to use telemedicine visits.

I REFUSE to participate in telemedicine visits as described above.

Patient Signature: _____ Date: ____/ ____/ _____