



## VERBAL CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION/TREATMENT

**Note: Please read this or watch the video to inform you about your upcoming telemedicine visit. You will be asked by your provider if you agree with this document and understand it. You can ask your provider any questions you may have.**

1. I authorize and voluntarily consent to the participation and treatment of myself or child in a Telemedicine Consultation and/or treatment with Children's National Hospital ("Children's National").
2. I understand that as a participating patient, my physician and I will communicate by interactive television (videoconferencing) with physicians, mental health providers, and health care professionals at Children's National. I understand that medicine is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examinations and treatments.
3. It has been explained to me how the video conferencing technology will be used to conduct a visit. I understand that this visit will not be the same as an in-person visit due to the fact that my child will not be in the same room as the healthcare provider at the distant site. I also understand that I have the option to see a provider in person, if I chose.
4. I further understand that there are potential risks to telemedicine, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand that either the healthcare provider or I can discontinue my child's telemedicine health visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand it may be necessary and useful for others to be present during the visit other than my child's healthcare team and provider in order to operate the video equipment. These individuals are bound to maintain confidentiality of all information obtained. I further understand that I have the right to request the following when nonmedical personnel are present to: (1) omit specific details of my child's medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the examination room; and/or (3) terminate the visit at any time.
6. During my child's telemedicine visit, I understand that the responsibility of the telemedicine healthcare provider concludes upon the termination of the video conference connection and Children's National is not responsible for the actions of the distant site.
7. Any interview, tape, film, or photograph made of my child will be used for medical purposes and maintained by Children's National as confidential medical records, consistent with Federal and State law.
8. By signing this consent, I authorize my physician to release any relevant medical information, pertaining to my child's medical condition and medical care to Children's National, its physicians, mental health providers, and healthcare professionals. I also authorize Children's National, or its providers, to release any and all information to my insurance company or any other agent that may be responsible for paying my medical bills. I further understand and consent to being interviewed, taped, filmed, or photographed by my physician and/or Children's National.



**Children's National.**

9. I understand that I have the right to withdraw my consent at any time. If at any time I am not satisfied with the services rendered, I may file a complaint with the Children's National Ombudsman team.

10. I have read (or have had read to me) this document carefully, and hereby consent to participate in the Telemedicine consultation/services under the terms described above.