0 2 7 6 4

Children's Hospital of The King's Daughters Health System, Inc.
601 Children's Lane, Norfolk, VA 23507

CONSENT FOR TELEMEDICINE CONSULTATION

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

I hereby request and consent to medical and/or diagnostic treatment in a Telemedicine Consultation arranged by Children's Hospital of The King's Daughters, Incorporated ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG") and hereby authorize such entities and their physicians (and whomever he/she may designate as his/her assistant(s), including Residents and any CHKD staff physician) and employees to treat me, my child, or a minor in my legal custody ("Patient") upon presentation of necessary supporting documentation, in a Telemedicine visit with an outside consultant.

I understand that my health professional, _____, offered for me to participate as a Patient in a Telemedicine consultation at Children's Hospital of The King's Daughters with

Print Name:_____ Credential _____ whose credentials are incorporated in this Consent..

I understand that:

1) I, the Parent/Legal Guardian/Patient, and/or my health care professional(s) at CHKDHS and/or CSG will through interactive video conferencing be able to consult with the above-named consultant about my condition who may offer medical and/or diagnostic treatment. Moreover, I agree that it is the role of the health care professional to determine whether the condition being diagnosed and/or treated is appropriate for a telemedicine encounter.
2) The telemedicine consultant practices in a different location and does not have the opportunity to meet with me face-to-face. Therefore, she/he must rely on information provided by me and my onsite healthcare professional(s). The CHKDHS and/or CSG providers and affiliated Telemedicine consultant cannot be responsible for advice, recommendations and/or decisions made based on incomplete or inaccurate information provided by me or others.
3) Other individuals may be present to operate the video equipment to facilitate this consultation, and their participation along with all involved health providers will be pursuant to federal and state health privacy laws.
4) A limited physical examination may be conducted during the videoconference, some portions of which may be conducted by health professionals at my location at the consultant's direction.
5) I may request that the telemedicine consultation and/or videoconference be discontinued at any time without affecting my right to future care or treatment.
6) I know there are potential risks with the use of this new technology. These risks include but are not limited to:
   a) Interruption of the audio/video link;
   b) Disconnection of the audio/video link;
   c) A picture that is not clear enough for medical decision-making by my health care professionals, including the consultant; and/or
   d) Electronic tampering resulting in a breach of privacy of patient health information.
7) If any of these risks occur, the Telemedicine consultation may need to be stopped, which could lead to a delay in medical evaluation and treatment. In addition, I may be required to go to the location of the Telemedicine consultant to further facilitate my diagnosis.
8) In conjunction with the Telemedicine Consultation, digital images may be made and sent to physicians and/or other health care professionals at CHKDHS and/or CSG for evaluation and consultation with my Telemedicine consultant for medical and/or diagnostic treatment purposes.

By signing this consent, I authorize the Patient's health professionals, including the Telemedicine consultant, to release any relevant medical information pertaining to the Patient's medical condition and medical care to CHKDHS and/or CSG physicians and/or associated health care professionals for continuing care purposes. I authorize CHKDHS and/or CSG to release any and all necessary information to the Patient's insurance company or any other agent which may be responsible for paying the Patient's medical bills. I authorize the use of electronics as described to facilitate the Telemedicine Consultation and release CHKDHS and CSG from any and all past, present, or future claims, demands, liabilities, actions, causes of action, or suits of any kind directly or indirectly arising out of or involving the use of such technology, including any loss of information due to technical failure and/or decision on my part to discontinue the consultation prematurely.

I have carefully read and understand this Telemedicine Consent, discussed it with my health professional and/or such assistants as designated, and all questions have been answered to my satisfaction. I have been given no guarantee or assurance as to the results that may be obtained. I certify that I am the Patient or the Patient's parent or legal guardian, and I have the authority to grant this consent and hereby consent to the Patient's participation in the Telemedicine consultation under the terms described above.

Thank you for selecting Children's Hospital of The King's Daughters Health System as your Health Care Provider.

PATIENT NAME	DATE OF BIRTH

SIGNATURE OF PARENT	RELATIONSHIP TO PT/LEGAL AUTHORITY	DATE	TIME

WITNESS SIGNATURE	DATE	TIME

For Office Use only:

2ND WITNESS (VERBAL CONSENT ONLY)	DATE	TIME	NAME OF PERSON ACCOMPANYING PATIENT