PRESTON
MEDICAL SPECIALISTS

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30 Kenneth Street, Preston VIC 3072
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TELEHEALTH CONSULTATION PATIENT PARTICIPATION CONSENT

I _____ (patient name) consent to participate in a clinical consultation with _____ (Specialist name) via TeleHealth.

By consenting, I understand and agree to the following:

- This consultation is carried out using video and audio technology and some technical problems may arise during the consultation
- A General Practitioner, nurse practitioner and/or a support person may be in attendance
- The Specialist will not conduct a physical examination; however, if deemed appropriate, this may be undertaken by my health care practitioner in attendance
- My participation is voluntary, and I may withdraw participation at any time
- If I, the healthcare practitioner with me, or the Specialist have any concerns about the quality of the consultation, an in-person consultation may be recommended/requested
- Prior to and during the consultation, medical information (images, pathology and my medical history) may be provided by me or my General Practitioner to the Specialist in order to conduct the consultation.
- All information will be treated confidentially by the Specialist in accordance with applicable privacy laws.
- My medical information may however need to be disclosed with other healthcare providers to procure additional healthcare services on my behalf (such as referrals to other providers)
- I will provide accurate information during the consultation to ensure services are be provided adequately. I understand that failure to do so may impair diagnosis with consequent adverse medical outcomes
- The audio/video technology used has been developed using all reasonable measures to protect your privacy and security. However, telecommunications are vulnerable to third party attack and interference. Therefore, it cannot be guaranteed that video consultations will at all time be secure.

  By signing this form, I acknowledge that I have read and understood (or have been explained) the information in this form and that give my consent to participate in a consultation with the Specialist.

  Signature of Patient / authorized representative: _____

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Date: _____

If authorized representative, relationship to patient: _____