Michael J Lucherini MD MS
RED MOUNTAIN PROFESSIONAL PARK
6828 EAST BROWN ROAD, SUITE 102
MESA, AZ 85207-3761

T. 480.981.9000 F. 480.656.0098
WWW.SUMMITMEDPEDS.COM

TELEMEDICINE CONSENT

PATIENT:______________________________________ DOB:_______________ DATE:______________

I authorize Dr. Lucherini to utilize telemedicine in determining my diagnosis and/or treatment. I understand telemedicine means the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occurs in the physical presence of the patient.

Michael J Lucherini MD MS at 6828 East Brown Road, Suite 102, Mesa, AZ 85207 will be consulted through audio, video or data imaging and communications.

Benefits

Telemedicine is being utilized for the following reason(s):

- Convenience of encounter for the patient
- Access to healthcare technology not physically readily available
- Need for expertise from a consultant not readily available
- Reduce risk for exposure to infectious disease (e.g. COVID-19)

Risks

The reasonably foreseeable risks of utilizing telemedicine may include:

- Audio or visual images may not be as reliable or accurate as in person.
- Telemedicine physicians cannot utilize the senses of touch and smell to diagnose or treat
- Telemedicine platforms may not be designed to optimize protection of health information

Alternatives

The possible alternatives may be:

- Travel to see physician or consultant in person or to undergo the testing/procedure.
- Undergo therapy available locally which may not produce desired result.
- Telephonic communication (without video or data communication) with physician or consultant

Confidentiality

I understand every reasonable effort will be made to protect the security and confidentiality of my medical information which is copied and forwarded to the above named consulting physician either through the mail or transmitted through electronic means as part of telemedicine.

Option Not to Participate

I understand I have the option of not participating in telemedicine and can withdraw from participation in utilizing telemedicine technology in my diagnosis or treatment at any time by expressing this to my physician.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

____ ______________
PATIENT | LEGAL REPRESENTATIVE DATE

PHYSICIAN DECLARATION: I have explained the contents of this document with the patient and have answered all the patient's questions. The patient has been adequately informed and has consented.

____ ______________
PHYSICIAN SIGNATURE DATE