**Consent for telemedicine consultation at the Kerry Skin Clinic  
 (video consultation via your phone/tablet/laptop/PV**)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that Dr Buckley wishes me to engage in a telemedicine consultation using a safe, secure, encrypted platform (www.doxy.me).

2. Dr Buckley has sent me information explaining how the video conferencing technology will be used.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties although Dr Buckley has taken every precaution to try to prevent this from happening.

 I understand that Dr Buckley or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with Dr Buckley’s Receptionist for scheduling and billing purposes. The receptionist will maintain confidentiality updating information obtained.

5. I have had the alternatives to a telemedicine consultation explained to me, and I  choose to participate in a  telemedicine consultation. I realise that a physical examination, taking samples for investigations and hands-on treatments are not possible with teleconsultations.

6. I understand that billing will be issued to private patients  from  Dr Buckley for telemedicine consultations. If a subsequent face to face visit is required a separate bill may be issued for the follow up visit.

7. I have  had the opportunity to ask questions in regard my telemedicine consultations.  My questions have been answered and the risks, benefits and any  practical alternatives have  been discussed with me in a language in which I understand.

**I  will have the right to request the following:**  
 (a) omit specific details of my  medical history/physical examination that are  personally  sensitive.  
 (d)   terminate the consultation at any time without affecting my right to future care or treatment.

**By signing this form, I certify:**

That I have read or had this form read and/or had this form explained to me

That I fully understand its contents including the risks and benefits of the video consultation

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s/parent/guardian signature      Date