INFORMED CONSENT FOR TELEDENTISTRY

I, ________________________________, hereby authorize and request, Dr. ______________________, to provide to me dental professional services using electronic and/or digital communications, or teledentistry.

I acknowledge the following:

a) The potential for breach of confidentiality, or inadvertent access, of protected health information using electronic and digital communication in the provision of care; and
b) The potential disruption of electronic and digital communication in the use of teledentistry.

I permit Dr. ______________________________ to use teledentistry services to provide care for

[activities: ____]

I acknowledge that it is Dr. _______________________’s role to determine whether the condition being diagnosed or treated is appropriate for a teledentistry encounter.

Risks, benefits and alternatives. The benefits of teledentistry include having access to a dentist and additional dental information without having to travel to a dental office or clinic. A potential risk of teledentistry is that a face-to-face consultation with a dentist may still be necessary after the teledentistry appointment. This could be because of my specific medical or dental condition or for other reasons. Recommendations will be made to me about my future dental care after the teledentistry consultation. These could include recommendations about whether or not to see a dentist, specialist, or oral surgeon in a dental office or dental clinic. A visit to a dental office may be needed in the future even if it is not recommended now. The recommendations may change if more information about my dental needs becomes known. The alternative to teledentistry consultation is a face-to-face visit with a dentist.

I may choose not to participate in a teledentistry consultation at any time before and/or during the consultation. If I decide not to participate, it will not affect my right to future care or treatment. I have the option to seek dental consultation or treatment in a dental office at any time before or after the teledentistry consultation.

Dr. ______________________________ has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all my questions have been answered. I agree to have records, including electronic versions of X-rays, photographs, charting of conditions, and health and other history information, collected from me and shared and used as described in this consent form I have received. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment I have requested and authorized.

Signed By____Date__________________________

patient, parent, guardian (please circle)

Signed By____Date__________________________

Doctor

Signed By____Date__________________________
Witness