

**Patient consent form for use of Tele-Derm service.**

I ....., acknowledge that my doctor is seeking information and guidance on the diagnosis and management of my condition from a qualified dermatologist at Tele-Derm. This involves transmission of details of my case, including images over the internet. I have checked with my doctor that no details or images sent can reveal my identity. I acknowledge that the internet is not a totally secure medium and third parties may be able to gain unauthorised access to my Tele-Derm consultation. I realise that a face to face consultation with a dermatologist is less likely to result in an error of diagnosis or management.

I understand that I can instead be referred to a dermatologist for a face to face consultation if I wish.

I understand that dermatologists at Tele-Derm are merely giving my doctor information and guidance. They will not be responsible for the diagnosis and management of my condition.

I understand that all decisions on the diagnosis and management of my condition will be made by my doctor, [insert referring doctor's name].

I understand that I may still need to see a dermatologist face to face if my condition cannot be managed by my doctor after consultation with a Tele-Derm dermatologist.

I consent to my case being posted on the Tele-Derm web site for educational purposes. [Delete if consent not given].

I acknowledge that the Tele-Derm service is hosted by the Australian College of Rural and Remote Medicine ("ACRRM") and funded by the Commonwealth Government as represented by its Department of Health. The Department and ACRRM, and their respective directors and other officers and employees, partners, agents and sub-contractors make no representations or warranties and do not accept any liability from any person for the information or guidance (or the use of such information or guidance) which is provided on the Tele-Derm website or as part of the Tele-Derm service.

This Consent may be relied upon by the Doctor, Department of Health, the Tele-Derm dermatologists, the Commonwealth Government and ACRRM (including their directors and other persons mentioned above).

Signed.....

Date .....

Witness..... [referring doctor]