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PATIENT CONSENT FOR TELE-HEALTH COMMUNICATION

____I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

____I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice.

____I will be able to hear and see the healthcare provider.

____I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

____I understand that I will be responsible for any copayment or coinsurance that apply to my telemedicine visit.

____I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

____I understand that by signing this form that I am consenting to receive health care services via telemedicine.

By signing below you state that you have read, understand, and agree to the above Informed Consent for Telemedicine.

_____ _____

SIGNATURE OF PATIENT / GUARDIAN PRINT PATIENT'S NAME

_____ _____

PRINT NAME OF LEGAL GUARDIAN DATE