Name: _____

Date of Birth: _____

Consent to Participate in Telemedicine

This facility and its affiliated healthcare providers may arrange for you to connect with providers using audio/video technology to communicate and conduct a patient visit with the provider. If you have any questions about the use of telemedicine technology itself or any of the information below, please ask your Facility Provider.

1. I understand that my health care provider, _____, wishes me to engage in telemedicine visit(s) with Rocio Blas, LCSW.

2. My healthcare provider has explained how video conferencing technology will be used to conduct the visit(s). I understand this differs from a direct patient/healthcare visit because I will not be in the same room as my healthcare provider.

3. By using video conferencing technology, I understand and agree that there are risks associated with it, such as:
   - The information I transmit may be insufficient to allow for appropriate medical decision-making by the provider.
   - Failures of equipment, including interruptions, unauthorized access, and technical difficulties.
   - Unauthorized access to your medical information. I acknowledge that although the facility and its telehealth technology vendor strive to prevent unauthorized access to information about me through encryption and other security measures, the facility and vendor cannot guarantee that your use of the technology and the information will be private or secure, and you consent to this risk.

4. I understand that my healthcare information may be shared with others for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider to operate the video equipment. Those people will all maintain the confidentiality of the information obtained.

5. I acknowledge and agree that I am solely responsible for ensuring that the information submitted or transmitted by me through video conferencing technology is accurate and complete. I understand the provider will rely on this information to diagnose and prepare a treatment plan for my medical condition. Failure to do so may delay my treatment, cause misdiagnosis, or cause the incorrect submission of billing/claims.

6. I have had the alternatives to a telemedicine visit explained to me, including having a traditional face-to-face visit with a provider. I also understand that I have the right to stop the telemedicine visit at any time and revoke this consent. Upon revocation, I understand I may not be able to continue to receive care using telemedicine technology.

By signing this form, I acknowledge that I have read this document carefully, understand the risks and benefits of telemedicine consultations, have had the opportunity to ask questions, and consent to the terms listed above.

Signature of Patient (or the person authorized to sign for the patient): _____

If authorized signer, relationship to patient: _____

Date: _____