Telemedicine Visit Consent Acknowledgment

By signing this document, you acknowledge and agree to participate in a telemedicine consultation. Please read the following statements carefully:

- I understand that telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.
- I understand that information transmitted electronically may be used for diagnosis, treatment, follow-up, and/or education, and may include my medical records and images.
- I understand that all federal and state confidentiality laws apply to telemedicine.
- I understand that I have the right to withhold or withdraw consent to telemedicine at any time without affecting my right to future care or treatment.
- I understand that there are potential risks to technology, including interruptions, unauthorized access, and technical difficulties.
- I have had the opportunity to ask questions about this telemedicine session and such questions have been answered to my satisfaction.

By signing below, I acknowledge that I have read, understood, and agree to the terms described above for telemedicine services.

_____

Patient/Parent/Guardian Signature

Date: _____