PINNACLE
RHEUMATOLOGY

Informed Consent for Telemedicine Services

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE: _____

EMAIL: _____

I understand that telemedicine is the use of electronic information and communication technologies by Pinnacle Rheumatology to deliver services when I am located at a different site than the provider; and I hereby consent to Pinnacle Rheumatology providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. My insurance carrier may have access to my medical records for quality review or audit.

I understand that I will be responsible for any professional fees that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Pinnacle Rheumatology at (480) 770-4093. As long as this consent is in force and has not been revoked, Pinnacle Rheumatology may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient: _____Date: _____

If minor, signature of parent or guardian: _____

I have been offered a copy of this consent form (patient's initials) _____