HOWARD 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 Howard Rheumatology to deliver services to an individual when he/she is located at a different site then the provider; and hereby consent to Howard 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. Your insurance carrier will have access to your medical records for quality review/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 in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting Howard Rheumatology at (480)485- 5440. As long as this consent is in force or has not been revoked. Howard Rheumatology may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of the Patient: _____ Date: _____

If minor, signature of parent or guardian: _____

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