Patient Name: ___________________________ DOB: ____________________________

Medical Consent Form HIPPA Consent

- I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to providing health care services to me via telemedicine.
- I understand that telemedicine is being use for the treatment of my case.
- I understand that the laws that protect privacy and the confidentiality of medical information (HIPPA) also apply to telemedicine. I will not discuss the issues outside this forum with anyone, to respect their privacy.
- I understand my insurance carrier will have access to my medical records for quality review/audit.
- I understand that I will be responsible for any copayments, coinsurances and co-deductibles that may apply to me during this telemedicine visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment in the office or any future telemedicine visits.
- I may revoke my consent orally or in writing at any time by contacting Kronos Health/Integrated Center of Group Medical Visits at 978-655-6652.

____________________________________ ______________________________

Name (Parent if minor/ Guardian) Date

____________________________________ ______________________________

Signature (Parent if minor/ Guardian) Duration (1year)