Telemedicine Patient Consent Form

Patient Name _____ DOB _____/_____/_____

- ☐ I, (name of patient or parent/guardian)_____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care.

- ☐ I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

- ☐ I understand that with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

- ☐ I understand that medical records of telemedicine services will be kept at the office of ENT Specialists of Arizona.

- ☐ CMS has waived certain restrictions on telehealth during the COVID-19 emergency. As such, non-HIPAA compliant platforms such as FaceTime and Skype are allowed temporarily. I understand that by using said platforms, HIPAA privacy and security are not guaranteed.

- ☐ I consent to all associated fees for telehealth services.

☐ I attest that I am _____ _____

(Name) (DOB)