GAFFAR SYED, MD PA

Telemedicine Session

Patient Authorization and Consent Form

PATIENT NAME: _____DOB: _____

1.PURPOSE: The purpose of this form is to obtain your consent in a telemedicine consultation in connection with your scheduled appointment.

2. NATURE OF TELEMEDICINE CONSULT: During this telemedicine consultation:

- The provider may talk to you about your health history, exams, x-rays, lab results and other tests.
- A visual and/or partial physical exam may take place. This may happen by video, audio, and/or with other technology tools. A nurse or other healthcare staff may be in the room with you to help with the exam.
- Non-medical staff may be in the room to help with the technology.
- A report of the session will be placed in your medical record. You can get a copy from the office is requested.

3. MEDICAL INFORMATION AND RECORDS: All laws about privacy of your health information and medical records apply to telemedicine.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telemedicine consultation.

5. RIGHTS: You may withhold or withdraw consent to telemedicine consultation at any time without affecting your right to future care or treatment.

6. RISKS, CONSEQUENCES AND BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. You understand the information provided above.

I agree to participate in a telemedicine consultation.

Signature: _____Date: _____

If signed by someone other than the patient, indicate relation _____

Witness: _____

Written Name: _____