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TELEMEDICINE INFORMED CONSENT

Telemedicine allows patients to access medical care using audio-video interface such as videoconferencing.

Telemedicine services may be offered as sole or partial treatment. Telemedicine services involve the use of audio, live video (like Skype, Zoom, Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session as part of your ongoing treatment.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional and unintentional corruption.

Additionally, in RARE circumstances security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
- 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 or treatment. However, I understand I may have to travel further to obtain care.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
- I understand that it is my duty to inform my provider of any other healthcare providers involved in my medical/ psychiatric care.

I have read and understand the information provided about regarding telemedicine, have discussed it with my healthcare providers or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Sarah Fishman MD, PhD. to use telemedicine in the course of my diagnosis and treatment.

_____ ____/____/____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____
Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.