Informed Consent for Telemedicine Services

Patient Name:_____ **Medical Record #:**_____

Date of Birth: _____

Physician Name: _____ **Date Consent Discussed:**_____

I understand that telemedicine is the use of electronic information and the 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 **Linthicum Pediatrics** 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. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments, coinsurance, or deductible that applies to my telemedicine visit. If my insurance does not cover telemedicine, I understand I will be responsible for the balance.

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 rights to future care or treatment. I may revoke my consent orally or in writing by contacting Linthicum Pediatrics at 667-888-7337. As long as this consent is in force (has not been revoked) **Linthicum Pediatrics** may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person Authorized to sign for patient):

_____ **Date:** _____

If authorized signer, relationship to Patient: _____

Witness: _____ **Date:** _____

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