To be completed by Provider:

Patient Name:	Date of Birth:
Patient Address:	Date Consent Discussed:

I understand that telemedicine is the use of electronic information and communication technologies by health care provider to deliver services to an individual when he/she is located at a different site that the provider; and hereby consent to providers listed below providing health care services to me via telemedicine.

I understand that the laws that protect the 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 or coinsurances that apply to my 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. I may revoke my consent orally or in writing at any time by contacting the providers listed below. If the consent is in force (has not been revoked) the providers listed below may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

Providers:

Dr. Riaz Syed, MD
Katrina Garrigan, PA
Patricia Powers, NP

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 form (Patient's initials): _____

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