RICHMOND
Family Medicine

TELEMEDICINE CONSENT FORM:

PATIENT NAME: _____DOB:_____

I understand that telemedicine is the use of electronic information and 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 Richmond Family Medicine 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 never be recorded during a telemedicine session.

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 in the course of 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 Richmond Family Medicine. As long as this consent is in force (has not been revoked) Richmond Family Medicine may provider health care services to me via telemedicine without the need for me to sign another consent form.

Patient (or Guardian) Signature: _____ Date: _____

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