PONTE VEDRA CONCIERGE MEDICINE

TELEMEDICINE CONSENT FORM

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving information may be used for diagnosis, therapy, follow-up and or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

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

1. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation

    - Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals using interactive video, audio, email, and telecommunication technology.

    - Video, audio and/ or photo recordings may be taken of you during the procedure(s) or service(s)

2. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this or information for this telemedicine interaction to researchers or other entitles shall not occur without your consent.

3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation.

4. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

5. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Florida, and Florida law shall apply to all disputes.

6. RISKS, CONSQUENCES & BENEFITS: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have

been answered, and you understand the written information provided above.

- o I agree to participate in a telemedicine consultation for the procedure(s) described above.
- o I refuse to participate in a telemedicine consultation for the procedure(s) described above.

I have read and understand the information in this agreement. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I agree and give my consent to the use of telemedicine for medical care.

Patient Print

Patient Signature

Patient Date of Birth

Date

Parent, Guardian, or Legal Representative Signature

Witness of Signature