INFORMED CONSENT FOR TELEMEDICINE SERVICES

Lori McAuliffe, M.D., P.A.

Patient Name : ______________________________ **Date of Birth:** __________________

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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 the physicians and staff of LORI MCAULIFFE, M.D., P.A. 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, my insurance carrier will have access to my medical records for quality review/audit.

I understand that I will be responsible for any co-payments or co-insurances 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 in writing at any time by contacting LORI MCAULIFFE, M.D. at 405 Pasadena Ave. South, St. Petersburg, FL 33707. As long as this consent is in force (has not been revoked), LORI MCAULIFFE M.D., P.A. may provide healthcare services to me via telemedicine without the need for me to sign another consent form.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(s)) **Date**

____

If authorized signer, relationship to patient(s)

____ ____________________

Witness Date

Witnessed by: ____ C.Z. ____ E.T. ____ P.N. _____ L.I. ____ A.C. ____ B.H. ____ M.M. ____ N.S.