Vive Dermatology

1250 Ocean Parkway
Suite LN
Brooklyn, NY 11230

(718) 500-3505
vivedermatology.com

Informed Consent for Telemedicine Services

• I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

• I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider. I understand that my voice and image may be recorded in order to assist the medical or registration personnel and I consent to any such audio and video recording.

• I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.

• I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

• I understand that I will be responsible for any copayments, coinsurances or deductibles 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 effecting my right to future care or treatment.

• I understand that by signing this form that I am granting permission to all providers and ancillary staff to engage in Telemedicine services with me. If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

• 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. As long as this consent is in force (has not been revoked) telemedicine healthcare services may be provided to me without the need for me to sign another consent form.

Client/Guardian Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____