Urological Associates of Bridgeport, P.C.

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TELEMEDICINE PATIENT CONSENT FORM

Patient Name _____Date of Birth_____/_____/_____
(Print) First Middle Last

The purpose of this form is to obtain your consent to participate in a telemedicine visit with a clinician from Urological Associates of Bridgeport, P.C.

During the telemedicine visit: a. Details of your medical history, examinations, xrays and/or tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunications technology. b. a physical examination may take place. c. video, audio and/or photo recordings may be taken of you during the visit.

All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine visit. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any identifiable images or information for this telemedicine interaction, to researchers or other entities shall not occur without your consent. In rare cases, it may be determined that the information transmitted is of poor quality, requiring a face to face visit. This may cause a delay in medical evaluation/treatment. Security protocols could fail or not be available, causing a breach of privacy of personal medical information.

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associates with the telemedicine visit, and all existing confidentiality protections apply to information disclosed during this telemedicine visit.

You may withhold or withdraw consent to the telemedicine visit at any time without affecting your right to future care or treatment.

Your healthcare provider 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 visit. All your questions have been answered, and you understand the written information provided above.

You understand that certain fees for service may be waived during the COVID-19 pandemic depending on your insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, you may be responsible for any copayments, deductibles or coinsurances that apply, and if your medical insurance coverage is not sufficient to satisfy any excess costs, you will be responsible for payment.

I have read the information above and hereby authorize my provider to use telemedicine in the course of my diagnosis and treatment.

Name of patient _____ Date _____/_____/_____
First Middle Last
If signed by someone other than the patient, indicate relationship _____

_____Date _____/_____/_____
Signature of patient/someone other than patient

_____Date _____/_____/_____
Witness

5/14/20