

INFORMED CONSENT FOR TELEMEDICINE SERVICES

TABLE TO BE COMPLETED BY PROVIDER:

Patient name: _____

Location of patient: _____

Date of birth: _____ Medical record number: _____

Physician name: _____ Location: _____

Date consent discussed: _____

I understand that my telemedicine appointment is the use of electronic information and communication technology by my provider who will deliver medical advice via telemedicine; I hereby consent to Oakdale ObGyn to provide these healthcare services to me.

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 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 Oakdale ObGyn at 763-587-7000. As long as this consent is in force (has not been revoked) Oakdale ObGyn may provide health care services to me via telemedicine without the need for me to sign another consent form.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)

If authorized signer, relationship to patient: _____

Witness: _____ Date: _____

I have been offered a copy of this consent form (patient's initials): _____



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Early, late and Saturday appointments: 763-587-7000 • Visit OakdaleOBGYN.com     