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 via audio or video, the healthcare provider will be able to see my image on the screen, and/ or hear my voice. I will be able to see and /or the healthcare provider.

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

•I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit, charged during or after my care.

•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 consenting to receive health care services via telemedicine.

According to the "Preserve Telehealth Access Act 2021", telehealth coverage is expanded regardless of the patient's location at the time services are provided and also expands coverage to include audio-only telephone conversations. With certain limitations, reimbursement must be provided for a health care service appropriately provided through telehealth on the same basis and at the same rate as in-person delivery of the health care service. *https://www.mbp.state.md.us/forms/2021_legislative_summary.pdf*

_____ I wish to Opt-Out of Telehealth services and received only in person care.

_____ I wish to Opt-In to Telehealth services.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____