BAKER PEDIATRICS
PARTNERSHIP WITH FAMILIES

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 they are located at a different site than I am.
- ☐ I understand that the telemedicine visit will happen through the telephone or a video call.
- ☐ I understand that the laws that protect privacy of medical information and the confidentiality of medical information including HIPPA, also apply t\o telemedicine.
- ☐ I understand that I will be responsible for any copayments and coinsurances that apply to my telemedicine visit.
- ☐ I understand that I have the right to withhold or withdraw my consent for the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- ☐ Iunderstand that by signing this form I am consenting to receive health care services via telemedicine.

Patient Name: _____

Patient DOB: _____

Parent/Guardian Signature: _____

Date: _____