TELEMEDICINE PATIENT CONSENT FORM

To participate, you must have an Android or Apple phone and Firefox or Chrome web browser.

PATIENT NAME: _____ DOB: _____

I, (name of patient or parent/guardian)_____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at the office of Topeka Ear, Nose & Throat.

I understand that my personal health information will not be recorded or data stored by the updox.com site. I understand that updox.com is HIPAA compliant.

Signature of patient (or parent/guardian): _____Date:_____

Please print the above name:_____

Signature of Witness: _____Date:_____