TELEMEDICINE PATIENT CONSENT FORM

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Please note: To participate you must have: Android or Apple phone or 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 at Oregon ENT Center.

I understand that my Personal health information will not be recorded, or data stored by the Zoom site.

I understand that Zoom is HIPPA approved.

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

Please print the above name: _____

Signature of Witness: _____ Date: _____

_____**I wish to decline telehealth consultations at this time.**

Signature of patient: _____ Date: _____

Please print above name: _____