HEADACHE & PAIN
CENTER OF PALM BEACH

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Board Certified in Neurology | Board Certified in Pain Management
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Telemedicine Informed Consent Form

Patient Name: _____ **Date of Birth**: _____

I, _____ (patient name), hereby consent to engaging in telemedicine with the medical providers at the Headache & Pain Center of Palm Beach as part of my medical treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners. I understand that I have the following rights with respect to telemedicine:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my treatment is confidential.
- I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my medical provider, that the transmission of my medical information could be disrupted or distorted by technical failures.
- In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services.
- I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I have read and understand the terms of this Consent and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Patient Signature Date

If someone else is signing this Authorization on behalf of the Patient, please provide the following information:

_____ _____ _____
Legal Representative * Date Relationship to the Patient

Note: * Please provide written documentation to support your status as a legal representative and/or guardian.