Citrus Pulmonary Consultants
and
Sleep Disorders Center

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AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

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

PURPOSE: The purpose of this notice is to obtain your consent to participate in a telehealth consultation with Citrus Pulmonary Consultants and Sleep Disorders Center.

NATURE OF TELEHEALTH CONSULTATION: Details of your medical history, current conditions, examinations, plan of care and tests will be discussed through the use of interactive video, audio, and telecommunication technology. The telehealth consultation provider will rely on information collected from you during the consultation session – it is important to provide the most accurate information as possible to assist in developing your plan of care. The purpose for providing telehealth consultations is to make sure you get good, personal health care even though you are not meeting a provider in person.

Telehealth consultation providers must follow the same rules and best practices for prescribing medications as they would for an office visit.

MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. We do not record and store the audio and video session.

CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under Federal and Florida law apply to information disclosed during this telehealth consultation.

RIGHTS: You may withdraw consent to the telehealth consultations at any time without affecting your right to future care or treatment or risking loss or withdrawal of any program benefits to which you would otherwise be entitled.

BILLABLE SERVICE: You understand that the services provided by your health care provider through telehealth are considered a billable service and may be subject to your standard office visit copay or deductible amount.

I have been advised of the potential risks, consequences and benefits of telehealth. Representatives from my health care provider have discussed with me the information provided above. I have had the opportunity to ask questions about the information presented on this notice and the telehealth consultation. All my questions have been answered and I understand the written information provided above. By signing below and pressing the "Accept" button, I agree to participate in a telehealth consultation with Citrus Pulmonary Consultants and Sleep Disorders Center.

Signature:_____ Date:_____

If signed by someone other than the patient, indicate relationship:_____

Witness Signature:_____ Date:_____

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