CIRCLE CITY
GASTROENTEROLOGY

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Telemedicine Informed Consent Form

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6900 Brockton Ave., Ste 100, Riverside, CA 92506, TN: 951-808-6298, Fax: 951-523-7065

Please check as you understand each item in this consent form *

- ☐ I understand that telemedicine is the use by a health care provider of communication technologies available such as the internet for delivery of healthcare services via audio and video regardless to the location of the parties in communication.
- ☐ I understand the benefits with the use of telemedicine, as well as its limitations whereas there can be no guarantee to the results of all treatments made through this medium.
- ☐ I understand the limitations with the use of telemedicine where it cannot be fully equal to face-to-face mode of treatment and such delays may incur due to possible cases of intermittent communication that may arise and which the telemedicine service provider is of no fault.
- ☐ I understand that there are state laws that help protect my privacy by standardizing confidentiality and information security that apply to telehealth and telemedicine consultations such as HIPAA. However, in case my insurance need access to my medical information, I hereby grant release of information requested to my insurance provider and/or its representatives.
- ☐ I understand that my participation is voluntary, and I have the right to withhold, or withdraw my consent to the use of the telemedicine anytime. I understand that my withdrawal does not affect any future treatment with the provider.
- ☐ I am aware and shall solely be responsible for any charges incurred with the use of telemedicine and shall inform the telemedicine service provider the mode of payment I shall prefer.
- ☐ I understand that I this telemedicine informed consent form has sole jurisdiction in the state of California and therefore I must be a resident in California to be treated through telemedicine.

By signing this form, I affirm my voluntary consent to this telemedicine engagement. I understand that each item above was explained to me. I was given the opportunity to ask my questions and the questions were answered accordingly and to my satisfaction.

Patient Name	**Date of Birth**
Patient Signature	**Date Signed**