Telemedicine
consent form

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I authorize **Dr. Belkys Bravo, M.D., and contracted providers** to provide me with their observations and recommendations regarding my medical condition and potential courses of action, using telemedicine. The use of telemedicine involves the electronic communication of my medical information. I understand that **Dr. Bravo, M.D., and contracted providers** is a healthcare Provider based in Florida and its contracted providers will not perform an in-person physical examination during the telemedicine consult. They will rely solely on the information telecommunicated. I authorize **Dr. Belkys Bravo, M.D., and contracted providers** to consult with any other physician specialists whom they may choose to involve in my case if necessary.

I understand that I have the following rights with respect to the telemedicine services performed by **Dr. Bravo, M.D., and contracted providers:**

Right to withdraw. I have the right to withhold or withdraw my consent to telemedicine at any time, without effecting my future right to health care or treatment and without risking the loss of my health coverage.

Access to information. I have the right to inspect all medical information transmitted during **Dr. Belkys Bravo, M.D., and contracted providers** telemedicine consultation, and may receive copies of this information for a reasonable fee.

Confidentiality. The laws that protect the confidentiality of medical information apply to telemedicine, and no information or images from the telemedicine interaction which identify me will be disclosed to other parties without my consent, except as permitted by law.

I understand that there are risks from telemedicine, including but not limited to: loss of records from failure of electronic equipment; power failure with loss of communication; and invasion of electronic records from outsiders (hackers). In addition, signs and symptoms that might be detected during an in-person physical examination may not be detected through telemedicine. I understand that I have the option of seeing another physician on a face to face basis who could provide me with observations and recommendations.

I warrant that the **Dr. Belkys Bravo, M.D., and contracted providers**/physician observations and recommendations are limited in scope and nature to the specific issues discussed during the telemedicine consult.

I have read and understand the information provided above. I agree and all my questions have been answered to my satisfaction. I consent to receiving the telemedicine services described above.

Patient's Name: _____ D|O|B:_____

Parent or Guardian:_____