The Center for Psychological Counseling Services, Inc.
5124 Hollywood Boulevard
Hollywood, Fl 33021
Tel: (954)894-1174 & Fax: (954)965-4597

Telemedicine Consent Form Florida

I understand that telemedicine is the use of electronic technology for communication for the purpose of providing healthcare services wherever the doctor and the patient are located. I understand that the institution is based in Florida and likewise uses telemedicine to conduct a consultation with their patients. I understand that with the use of telemedicine, the interaction shall be done through real-time audio-video communication. I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA) also apply to telemedicine. I understand that I will be responsible for any payments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment; I have the right to access my information and to inspect my medical information that was transmitted through telemedicine; I have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent. I understand any lawsuit airing out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states.

With the pronouncements above:

I authorize the Institution to provide me their diagnosis, observations, recommendations regarding my condition through telemedicine. Whenever necessary, I authorize the Institution to consult with other physicians or specialists whom they believe to have full knowledge and skills that can address my case. I have read and understood the information provided above, my rights, and obligations regarding telemedicine. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telemedicine for medical care.

☐ Please mark this checkbox if a parent/guardian shall sign this consent on behalf of the patient

Patient Name _____

Parent/ Guardian Name _____

Patient Phone Number _____

Patient Email (example@example.com)_____

_____ _____

Patient/Parent/Guardian Signature Date