

## TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) \_\_\_\_\_, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by those at Open Gate Acupuncture. [Note: The likelihood of this transmission being intercepted by persons other than those at Open Gate Acupuncture is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons.

I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation, when legally allowed.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at the consulting site facility.

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### Professional assistance

If you think you may be suffering from any medical condition you should seek immediate medical attention. You should never delay seeking medical advice, disregard medical advice, or discontinue medical treatment because of information on this website.

### Liability

Nothing in this medical disclaimer will limit any of our liabilities in any way that is not permitted under applicable law, or exclude any of our liabilities that may not be excluded under applicable law.

Printed Name: \_\_\_\_\_

Signature of patient (or parent/guardian): \_\_\_\_\_ Date: \_\_\_\_\_