

Rachel Zielinski LCSW

Informed Consent for Telemedicine Services

Patient Name:	Date of Birth:	Location of Patient:
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I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Rachel Zielinski LCSW providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical record for quality review/audit.

I understand that I will be responsible for any copayments 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 of treatment. I may revoke my consent orally or in writing at any time by contacting Rachel Zielinski LCSW at 95 Allens Creek Rd., Bldg 1, Ste 304 Rochester, NY 14618. As long as this consent is in force and has not been revoked, Rachel Zielinski LCSW may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for the patient)

_____ Date: _____

I have been offered a copy of this consent form (patient initials) _____