JIB MEDICAL, P.C.

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CONSENT TO TELEMEDICINE SERVICES

PATIENT NAME: ____
(Please Print)

PATIENT DATE OF BIRTH (DOB): __________________

PATIENT GENDER: ____

PATIENT PHONE: ( ) ____________________

If the LEGAL GUARDIAN of the Patient is authorizing the Telemedicine Services Consent described below (please print):

Name of Legal Guardian of Patient: ________________________________ **Phone/Cell Number:** ( ) ____________

Parent or Legal Guardian's Address: ____

CONSENT TO TELEMEDICINE SERVICES

I certify that I am the above (a) PATIENT and at least 18 years of age; *or* (b) LEGAL GUARDIAN of the Patient.

I understand that "telemedicine" involves the use of electronic communications to enable healthcare providers to treat patients at different locations or share information using interactive audio, video, or data communications. I understand that telemedicine may also involve the communication of my medical information, both orally and visually, and that the laws that protect the privacy and confidentiality of my medical information equally apply to telemedicine.

I acknowledge that there are risks and possible consequences associated with telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of JIB Medical and its affiliates and staff, that:

- **the transmission of my information could be disrupted or distorted by technical failures, which may delay treatment or diagnoses;**
- **the transmission of my information could be interrupted or accessed by unauthorized persons;**
- **the electronic storage of my medical information could be accessed and/or disseminated by unauthorized persons; or,**
- **medical examinations or evaluations may be limited by technical constraints, including the inability to perform physical examinations or full evaluations.**

Accordingly, I understand that, in the event that my condition worsens or if I refuse to appear for an in-person examination, I will immediately seek alternative or emergency care or follow the recommendations of my physician, including undergoing a full physical examination or evaluation.

I further understand that the Patient or Legal Guardian is responsible for providing the necessary computer, telecommunications equipment (camera and microphone), and internet access required to participate in the telemedicine session(s).

I understand that I may revoke or withdraw my consent to telemedicine in writing at any time except to the extent that action has been taken in reliance upon my consent.

I have read this document carefully, and understand and have had explained to me the risks, benefits, and my rights related to telemedicine, and accordingly, by my signature below as Patient or as their Legal Guardian, in addition to certifying and acknowledging my understanding of all of the aforementioned, I consent to the use of telemedicine services as administered by JIB Medical.

***PRINT NAME*:** ____

***AUTHORIZING SIGNATURE*:** ____ **DATE** ____________________________

PLEASE RETURN THE *SIGNED* AND COMPLETED CONSENT FORM BY USING ONE (1) OF THE FOLLOWING METHODS:
By E-mail: telemed@jibei.com
By Mail – JIB Medical, P.C. • 158-11 Harry Van Arsdale Jr. Avenue • Flushing, NY 11365
By Facsimile: (718) 591-9528