UNIVERSITY of MARYLAND
ORAL-MAXILLOFACIAL
SURGERY ASSOCIATES, P.A.

Patient _____

Date of Birth _____

CONSENT FOR TELEHEATH SERVICES

Telemedicine involves the use of electronic communications to enable health providers at different locations to share individual patient medical information for the purpose of improving patient care.

___ (initial) I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

____ (initial) I understand the telemedicine visit is a billable visit. I agree to be responsible for any copayments, deductibles, or other charges associated with any services provided to me by the provider.

____ (initial) I understand that UMOMSA and its providers offer telehealth-based medical services, but these services do not replace the relationship between me and my UMOMSA provider. I also understand it is up to the provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.

____ (initial) I understand that I have the right to withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

____ (initial) I understand the telehealth services are provided by a provider at a distant site and I am not in the same room as the provider. I understand that alternatives to telehealth visits, such as in-person services, are available to me.

____ (initial) I understand my medical information will be discussed during the telehealth service. I consent to any additional persons on my end of the service hearing the information discussed within the telehealth visit.

____ (initial) I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

____ (initial) I understand that additional persons may be present during the consultation other than the provider and staff in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

____(initial) I understand that at times the information and assessment gathered during a telehealth service may be insufficient given the nature of being in a location separate from the provider, and that there could be equipment failures or security failures leading to a breach in privacy.

____(initial)You have my permission to send the telemedicine invite to the following and they have my permission to join the telemedicine visit:

Name: _____ Email:_____

By signing below, I acknowledge that I have read and understand the above information regarding telemedicine and hereby give my consent for the use of telemedicine in my medical care.

_____ _____ _____

Signature- Patient/Guardian | Print Name | Date