Telehealth Patient Consent Form
Lighthouse Pediatrics of Naples, LLC

PATIENT NAME:_____**DOB:**_____

1. **PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):**

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2. NATURE OF TELEHEALTH CONSULT: During the telehealth consultation:

a. Details of your medical history, examination, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology

b. A physical examination of you may take place.

c. A non-medical technician may be present in the telehealth room to aid in the video transmission.

d. Video, audio and.or photo records may be taken of you during the procedure(s) or service(s).

3. MEDICAL INFORMATION AND RECORDS. All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are records and stored. Additionally, dissemination of any patient identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with the telehealth consultation, and all existing confidential protections under federal and Florida state law apply to information disclosed during this telehealth consultation.

5. RIGHTS: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment.

6. DISPUTES: You agree that any dispute arriving from the telehealth consult will be resolved in Florida, and that Florida law shall apply to all disputes.

7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information proved above. Your insurance will be billed for the telehealth consultation and you understand that any unpaid balance is your responsibility.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature:_____ Date:_____

Relationship to patient:_____