Aurora Optometric Group

980 West Maple Court Elma, NY 14059 716-652-0870

PATIENT NAME: ______________________________

PARENT/GUARDIAN: ___________________________________ DOB: _____________

DATE CONSENT: ____________ SIGNATURE: ____

BY SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE FOLLOWING:

Telehealth is the delivery of healthcare services through the use of technology when the healthcare provider and patient are not in the same physical location. Electronically transmitted information may be used for diagnosis, therapy, follow-up and/or patient education. During the telehealth consultation: Details of your medical history, examinations, and tests will be discussed with health professionals through the use of interactive video, audio, and/or telecommunication technology. A physical examination of you may take place. Video, audio and/or photo recordings may be taken of you during the service.

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. **I have consented to allow Aurora Optometric Group to bill my health insurance for a Teleheath visit, and I agree to pay for any portion that is not covered.**

The laws that protect the privacy and confidentiality of medical information also apply to telehealth. No information obtained during a telehealth encounter which identifies me will be disclosed to researchers or other entities without my consent. I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled. I have the right to inspect all information obtained and recorded during the course of a telehealth interaction and may receive copies of this information for a reasonable fee. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time.