TeleHealth Consent

I hereby consent to engaging in telemedicine with ***Srirengam Muralidhasan, M.D., LLC Provider***. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical information, both orally and visually, to health care practitioners.

The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my treatment is confidential. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my Provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my Provider believes I would be better served by another form of medical services (e.g. face-to-face services) I will be referred to a medical services provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of medical treatment, and that despite the efforts of my Provider, my condition may not be improve, and in some cases may even get worse. Therefore, I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I HAVE NO OTHER PRE-EXISTING MEDICAL CONDITIONS THAT HAVE NOT ALREADY BEEN DISCLOSED HERE. I understand that this visit/encounter does not and should not replace a traditional doctor's office visit; and therefore, I am proceeding with this tele-evaluation at my own risk and understanding. I also understand that should my condition or my responsible party's be an emergency, I should contact local emergency response by dialing 911. I certify that the information provided in this medical form is true and accurate to the best of my ability. I also understand that omitting medical information or misinforming a ***Srirengam Muralidhasan, M.D., LLC Provider***. may result in an inaccurate diagnosis and treatment.

I have read and understand the information provided above.

I have discussed it with a ***Srirengam Muralidhasan, M.D., LLC Provider***., and all of my questions have been answered to my satisfaction.

My signature certifies that I read and understood the scope of my consent.

_____ _____

Print Name Date of Birth

_____ _____

Patient or Guardian Signature Date