SYLVIA FOSTER, M.D., LLC
TELEHEALTH PATIENT CONSENT

Sylvia Foster, M.D., LLC (the "Practice") offers telehealth services to its patients in order to improve access to health care by enabling a patient to remain at home (or at a remote site) while receiving care from a distance.

I, _____, consent to receiving the following health care services:
_____
_____

My signature below (or other written acknowledgement of my acceptance to the terms above) indicates that I understand and agree to the following:

1. Telehealth involves the real-time evaluation, diagnosis, consultation on, and treatment of a health care condition using advanced telecommunications technology. The interactive audio & video systems used have network and software security protocols in place to protect the confidentiality of patients' information.

2. The feasibility of the telehealth visit will depend upon whether the information transmitted is sufficient. If the audio/video connection is inadequate or disconnected, the Practice may require an in-person visit.

3. In accordance with HIPAA, the Practice implemented safeguards to protect its patients' health information; however, the security and confidentiality of information transmitted electronically may be compromised by failure of safeguards or illegal or improper tampering.

4. It is my responsibility to provide complete and accurate information to my provider about my medical history, condition, and care because my provider will rely upon this information. My provider's advice, recommendations, and decisions may be based on factors not within their control (e.g., if I provide incomplete information or distortions of audio/video during the telehealth visit).

5. I must be located within the State of Maryland at the time of the telehealth visit. The Practice has the right to determine if a telehealth appointment is appropriate for my needs.

6. The Practice's Notice of Privacy Practices has more information about the State and federal laws governing the privacy and security of my medical records. Those standards will also apply to telehealth visits, and my provider will document this telehealth visit in my medical record. In accordance with HIPAA, the Practice will not record or store any video, images, or audio of my telehealth visit, and I also agree not to record or store any video, images, or audio of my telehealth visit.

7. It is my responsibility to determine in advance of the telehealth visit whether my device's operating system is compatible with technology utilized by the Practice. Additionally, I am responsible for securing the necessary internet or cellular data service and the fees associated with such service.

8. I may withhold or withdraw my consent to telehealth at any time without affecting my right to future care or treatment. I will contact the Practice at **443-775-9910** for any questions related to telehealth services.

Signature: _____ Date: _____