AMITA TALATI, MD
Board Certified Psychiatrist

Telemedicine Consent

Name:____________________________ **DOB:** ___________________________

Authorization and consent to Participate in Telemedicine Consultation

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s): Psychiatric Evaluation or Follow Up

2. **MEDICAL INFORMATION AND RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation.

3. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and New Jersey law apply to information disclosed during this telemedicine consultation.

4. **RIGHTS**: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting the right to future care or treatment.

5. **DISPUTES**: I agree that any dispute arriving from the telemedicine consult will be resolved in New Jersey, and that New Jersey law shall apply to all disputes.

6. **RISKS, CONSEQUENCES AND BENEFITS**: I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:____________________________Date: ________________

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