INFORMED CONSENT FOR TELEMEDICINE
Willow Breeze Wellness

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

Telemedicine Consent
I understand that my healthcare provider at Willow Breeze Wellness wishes to provide healthcare services to me using telemedicine in accordance with Ohio law. Telemedicine involves the use of interactive audio, video, or other electronic technology to provide healthcare services when the patient and provider are not in the same physical location.

My healthcare provider has explained to me how the telemedicine technology will be used during my consultation. I understand that this technology allows my healthcare provider and/or designee to communicate with me and, when appropriate, consult with other healthcare professionals regarding my condition.

Potential Risks of Telemedicine
I understand that there are potential risks associated with telemedicine, including but not limited to:
• The video or audio connection may not work or may be interrupted during the visit.
• The transmitted image or information may not be clear enough to allow for a full clinical assessment.
• I may need to seek in-person care if it is determined that telemedicine is not sufficient to diagnose or treat my condition.

Benefits of Telemedicine
I understand that the potential benefits of telemedicine include:
• Access to healthcare services without the need to travel.
• Increased convenience and timeliness of care.
• Access to specialty consultation when appropriate.

Confidentiality
I understand that my healthcare provider will take reasonable steps to protect the confidentiality of my health information in accordance with HIPAA and Ohio privacy laws. Individuals assisting with telemedicine technology may be present but are required to maintain confidentiality.

Examination Limitations
I understand that telemedicine involves a limited physical examination. Some parts of the examination may be conducted by me at my location under the direction of the healthcare provider. I understand that I may request to discontinue the telemedicine visit at any time.

Release of Information
I authorize the release of my relevant medical information to consulting healthcare providers, supervised staff, and third-party payers as necessary for treatment, payment, and continuity of care.

Recording and Media
I understand that telemedicine visits will not be recorded without my consent. I hereby release Willow Breeze Wellness, its providers, staff, and any persons participating in my care from liability arising from the authorized use of telemedicine technology, except in cases of gross negligence or willful misconduct.

Consent
I have read and understand this informed consent document. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I voluntarily consent to participate in telemedicine visits with Willow Breeze Wellness under the conditions described above.

Full Name (Print)_____**Signature:**_____

Date/Time: _____