

Telemedicine Consent Form

Patient Name: _____

The NYU Dental Faculty Practice will be using either ___ Facetime or ___ Zoom remote communication technology to conduct problem-focused evaluations/re-evaluations virtually, to help manage your oral health problem and to determine whether you have a condition that requires immediate in-office treatment. During the current pandemic the federal government announced that it will not enforce HIPAA regulations (privacy for health records) in connection with medical and dental offices' good faith provision of medical or dental services using non-public facing audio or video remote communications services.

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that any physical tests that may be conducted will be done at a different appointment that takes place at the practice
6. I understand that billing will occur from my practitioner.
7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By typing your name and date in the space below and returning via email, you certify the following:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

As always, our office takes medical record confidentiality very seriously, and will do what we can under the circumstances to protect the information you send us. While we believe the risk to such confidentiality is not high, it may be greater than it would be if these remote electronic communications were encrypted, which is one of the main HIPAA requirements that is being relaxed during the nationwide COVID-19 public health emergency.

Patient Signature:

Date: