KUMAR EYE INSTITUTE

Informed Consent for Telemedicine Services

By signing this form, I understand that:

The laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine will be disclosed to researchers or other entities without my consent.

I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.

Telemedicine may involve electronic communication of my personal medical information to other medical practitioners located elsewhere, including out of state.

I understand that no results from the use of telemedicine can be guaranteed or assured.

Consent. By signing below, you consent (agree) that:

I, _____ have read this informed consent form, or someone has read it to you.
I, _____ understand the information in this informed consent form and all of your questions have been answered.
I, _____ have been offered a copy of this informed consent form.

Signature: _____