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INFORMED CONSENT FOR DERMATOLOGY TELEMEDICINE SERVICES

Patient Name: _____ Location of Patient: State of Maryland: Y ___ N ___	Date of Birth: _____ Date Consent Discussed: _____, 202_
Name of Treating Healthcare Provider(s): _____ _____ SEE ABOVE FOR CONTACT INFORMATION	Alternative contact for Patient: Telephone: _____ E-mail: _____

Introduction

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Telemedicine services offered by Mark H. Lowitt, M.D., LLC ("Dr. Lowitt's Office") may also include chart review, remote prescribing, appointment scheduling, health information sharing, and non-clinical services, such as patient education. The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; (2) images and asynchronous communications; (3) live two-way audio and video; (4) interactive audio with store and forward; and (5) output data from medical devices and sound and video files.

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by enabling you to remain in your home while the provider from Dr. Lowitt's office consults and obtains test results at distant/other sites.

- More efficient medical evaluation and management.

- Obtaining expertise of a specialist as appropriate.

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.

- Our provider may determine that the transmitted information is of inadequate quality (e.g., poor resolution of images), to allow for appropriate medical decision making by the provider, thus necessitating a rescheduled telemedicine consult or the necessity for an in-office consultation.

- In rare events, security protocols could fail, causing a breach of privacy of personal medical information.

- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

- Our providers will not be able to perform certain diagnostic procedures during your telemedicine consultation, which may require scheduling an appointment at our office and which could delay the commencement of therapy.

By checking the box associated with "Informed Consent", you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving services from Dr. Lowitt's Office via telemedicine technologies. I also understand it is up to Dr. Lowitt's Office to determine whether or not my specific clinical needs are appropriate for a telemedicine encounter.

2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. These laws also apply to telemedicine. I understand that Dr. Lowitt's Office will take steps to make sure that my health information is not seen by anyone who should not see it, and that no information obtained in my telemedicine consultation which identifies me will be disclosed to other parties, without my consent.

3. I understand there is a risk of technical failures during the telemedicine encounter beyond the control of Dr. Lowitt's Office. I agree to hold harmless Dr. Lowitt's Office and its providers for delays in evaluation or for information lost due to such technical failures.

4. I understand that 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 understand that I may suspend or terminate use of the telemedicine services at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that Dr. Lowitt's Office will not able to connect me directly to any local emergency services.

5. I understand that alternatives to telemedicine consultation, such as in-person services are available to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of Dr. Lowitt's Office (e.g., labs or bloodwork).

6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

8. You will not be prescribed opoids for the treatment of pain as a result of the telemedicine consultation.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize healthcare providers from Dr. Lowitt's Office to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:*_____, 2020

*If authorized signer, relationship to patient:*_____

*Witness:*_____ *Date:*_____, 2020

I have been offered a copy of this consent form (patient's initials) _____