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F ERTILITY
S ERVICES

IN VITRO FERTILIZATION CENTER
HYPOTHYROIDISM
HORMONAL IMBALANCE

Informed Consent for Telemedicine Services

Table to be completed by Provider:

PATIENT NAME:_____	**DATE OF BIRTH:**
ADDRESS:_____	_____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to and individual when he/she is located at a different site than the provider, and hereby consent to Hugh D. Melnick MD providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

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 and treatment. I may revoke my consent orally or in writing at any time by contacting Hugh D. Melnick MD at Tel: 212-369-8700 Email: afsappointments@gmail.com. As long as this consent is in force Hugh D. Melnick MD may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient

(or person authorized to sign for patient): _____ ***Date:*** _____

If authorized signer, relationship to patient: _____

Witness: _____ ***Date:*** _____