

**Marco A. Renazco, MD, PA**  
**Katy Psychiatry**  
24215 Kingsland Boulevard  
Katy, TX 77494

**Telemedicine Consent**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City

State

Zip

DOB: \_\_\_\_\_

SEX: \_\_\_\_\_

DOS: \_\_\_\_\_

- I. Introduction.** Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time on a secure connection.
- II. Consent for Treatment.** I voluntarily request Katy Psychiatry provider(s) and such associates, residents, technical assistants and other health care providers as they may deem necessary (“Katy Psychiatry providers”) to participate in my medical care through the use of telemedicine.

I understand that Katy Psychiatry Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that Katy Psychiatry Providers’ advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If Katy Psychiatry Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

- III. Release of Information.** To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to Katy Psychiatry Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information; 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to Katy Psychiatry Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

This consent also confirms that Katy Psychiatry providers abide under HIPAA guidelines and in order to protect my Protected Health Information (PHI), I acknowledge that appropriate setting will be applied during my telemedicine communication with my provider. (e.g. a private, quiet place, with no other entity present, unless specified by the provider.)

I certify that this form has been fully explained to me, that I have read it, and that I understand its contents.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date