

ADVANCED
FERTILITY
SERVICES

IN VITRO FERTILIZATION CENTER
HYPOTHYROIDISM
HORMONAL IMBALANCE

MYTHYROIDMD

www.mythyroidmd.com



MYTHYROIDMD
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New York, New York 10128

Informed Consent for Telemedicine Services

Table to be completed by Provider:

| | |
|---------------------------------------|----------------------|
| PATIENT NAME: _____ ADDRESS: _____ | DATE OF BIRTH: _____ |
|---------------------------------------|----------------------|

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 or 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: mythyroidnyc@gmail.com. As long as this consent is in force (has not been revoked) Hugh D. Melnick MD may provide health care services to me via telemedicine without the need for me to sign another consent form.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: _____