Dawn Broderick, M.D. LLC
18111 Prince Philip Drive
Suite 201
Olney, MD 20832

Informed Consent for Telemedicine Services

PATIENT NAME: _____Date of birth: _____

PHYSICIAN NAME: ***Dawn Broderick, M.D. LLC, 18111 Prince Philip Drive, Suite 201, Olney, MD 20832***

By signing this form, I understand the following:

1. I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to *Dawn Broderick, M.D. LLC* providing health care services to me via telemedicine.

2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that my insurance carrier will have access to my medical records for quality review/audit/billing purposes.

3. 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 *Dawn Broderick, M.D. LLC* at *(301) 774-7714*. As long as this consent is in force (has not been revoked) Dawn Broderick, M.D. LLC may provide health care services to me via telemedicine without the need for me to sign another consent form.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: _____

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