



Telemedicine Consent Form

Consent to Telemedicine Services

I, the undersigned, consent to receiving health care services via telemedicine from Seema Kazi, MD, PA dba Mid Cities Psychiatry. I understand that this may involve the use of electronic communication to enable healthcare providers to share personal medical information, for the purpose of consultation, treatment, follow-up and/or education, and that my consent is voluntary. I understand that I have the option to withdraw consent at any time without affecting my future care.

Privacy and Security Acknowledgment

I acknowledge that Seema Kazi, MD, PA dba Mid Cities Psychiatry has explained the privacy and security measures that will be used to protect my health information. I understand that while electronic systems used 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, there remains a risk of such corruption.

Patient Rights and Responsibilities

I understand my rights to access medical information and records in the same manner as they would be provided during an in-person consultation and to receive all information concerning my health care and treatment. I agree to my responsibilities, which include providing complete and accurate health information and asking questions when I do not understand information or instructions.

I have reviewed and accepted the terms of Mid Cities Psychiatry's Telemedicine Policy. I agree to adhere to and be legally bound by these terms. I acknowledge that Mid Cities Psychiatry retains the right to amend its Telemedicine Policy at any time.