NEW YORK MEDICAL
Behavioral Health
Practice Focused on Integrated Psychiatry and Transcranial Magnetic Stimulation
890 Westfall Road, Suite B, Rochester, NY 14618
Phone: 585-442-6960 Fax: 585-442-3548

Informed Consent for Telemedicine Services

PATIENT NAME: _____

LOCATION OF PATIENT: _____

DATE OF BIRTH: _____

PHYSICIAN NAME: MAHIPAL S. CHAUDHRI, MD

LOCATION: 890 WESTFALL ROAD, SUITE B, ROCHESTER, NY 14618

DATE CONSENT DISCUSSED: _____

_____ 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 Mahipal S. Chaudhri, 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 will be responsible for any copayments or coinsurances that apply to my telemedicine visit. 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 in writing at any time by contacting Mahipal S. Chaudhri, MD at 890 Westfall Road, Suite B, Rochester, NY 14618. As long as this consent is in force (has not been revoked) Mahipal S. Chaudhri, MD may provide health care services to me via telemedicine without the need for me to sign another consent form.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: _____