Lederman and Lederman, LLP
Pediatric Ophthalmology
Strabismus

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PATIENT HIPAA AWARENESS AND TELEMEDICINE CONSENT

I give my consent for Lederman and Lederman, LLC (the "Practice") to use and disclose protected health information (PHI) about me or my child to carry out treatment, payment and operations, including telemedicine ("TPO").

The Practice may

- Call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders.
- Use an SMS Appointment Reminder service. Message frequency may vary and data rates may apply. Users can text keyword STOP to opt out. For help, contact the office at 914-417-6441. Carriers are not liable for messages that are delayed or undelivered. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All of the above categories exclude text messaging, originator opt-in data and consent. This information will not be shared with any third parties.
- Mail to my home or other designated location any items that assist the Practice in carrying out TPO, appointment reminders, insurance items and any other document(s) pertaining to my clinical care, including laboratory results.
- Release PHI to school authorities.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior request.

I grant the Practice to use telemedicine and understand that

- Telemedicine is a means used for remote communication and exchange of information, particularly for delivering health care services via an electronic medium such as the internet with facilities for audio and video communication, and
- That the laws that protect the privacy and confidentiality of medical information apply to telemedicine, and
- That the Practice cannot control the patient's environment when telemedicine is used, and
- That I may withhold or withdraw this consent to use telemedicine from the Practice and that should I withhold or withdraw this consent it will not affect my relationship with the Practice.

Patient Name: _____

Signature of Patient/Parent/Legal Guardian: _____