GENESEE ORTHOPEDIC & PLASTIC SURGERY ASSOCIATES, P.C.

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Phone (315) 735-4496 Fax (315) 624-9213
Email: medicalrecords@geneseeortho.com

TELEMEDICINE CONSENT AND REGISTRATION

Please mail, email, or fax the completed Patient Information form, along with this Consent form back to our office at least one day prior to your scheduled appointment.

(*Please be aware that if you choose to email patient health information that it will not be encrypted and could be at risk. You are choosing to accept this risk by doing so.)

By signing below I am consenting to and acknowledging the following:

- Receipt of Notice of Privacy Practices information.
- I give consent for Genesee Orthopedics to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care). This allows us to access any previous imaging studies you may have had done.
- I consent to the scheduled Telemedicine/Video Visit session.

Remember to find a private place where you can talk as it will be a video conference and can be seen and overheard by people around you. You can use your computer, tablet or smart phone. No information will be stored with any third-party platform other than the electronic medical record system already used by our practice.

I agree – please sign and date below. Please print your name and date of birth.

_____ Date: _____
Signature

Name: _____ DOB: _____

*If you are not a new patient and have previously completed this information you may disregard this notice. Thank You