AUTHORIZATION FOR TELEMEDICAL CONSULTATION

Patient Name: _____ **Date:** _____

- I understand that I am choosing to engage in a telemedicine consultation utilizing the MediOrbis platform and/or through its physician network MySpecialistMD Network PC ("MO/MSMDNet").
- I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical information, both orally and visually, to health care practitioners.
- MO/MSMDNet has explained to me how the telemedical conferencing technology will be used to provide such a consultation. I understand that this consultation will not be a face to face, in person meeting with my health care provider, but rather that it will be conducted via electronic communication.
- I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- I understand that the encounter on the MediOrbis platform will not be the same as a direct patient/provider visit due to the fact that I will not be in the same room as my health care provider and I accept this difference in quality.
- I understand that there are potential risks and benefits associated with any form of medical treatment, and that despite the efforts of my Provider, my condition may not be improving, and in some cases may even get worse. Therefore, I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
- I understand that either the provider or I can discontinue the telemedicine consult/visit at any time if it is felt that telemedicine is not adequate to address the situation, or for any other reason.
- I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the physical examination cannot be conducted via telemedicine or may be conducted by individuals at my location at the direction of the consulting provider. The provider will use his or her best judgment in determining whether such tests are needed, and the means for carrying them out. I wish to proceed with the telemedicine consultation despite this limitation.
- I certify that the information provided in this medical form is true and accurate to the best of my ability. I also understand that omitting medical information or misinforming a telemedicine Provider may result in an inaccurate diagnosis and treatment.

- I understand that some of my healthcare information may be shared with other individuals for scheduling and billing purposes. In addition, I provide my consent that healthcare information may be shared among physicians, their staff and their colleagues for the purpose of enhancing my patient care, diagnosis and therapeutic options. I further understand that I have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) terminate the consultation at any time.
- In an emergent consultation, I understand that the responsibility of the telemedicine consulting provider is to refer me to my local practitioner and that the provider's responsibility will conclude upon the termination of the telemedical consultation.
- I understand the risks, benefits and any practical alternatives to a telemedicine consultation. I have been afforded the opportunity to ask any questions or obtain any clarifications, as well as to consult with others about this process before making my decision.

- ***FOR INTERNATIONAL PATIENTS ONLY:*** *I understand that as an EU Patient, my rights under the GDPR Compliance Law grants me the ability to review, change, or terminate my Patient account at any time.*
    - *I further understand that* in specific regions, such as the European Economic Area, patients exert greater control over their Personal Protected Health Information (PPHI). Patients therefore have unique rights under applicable data protection laws.
        - **These may include the right**
            - (I) to request access and obtain a copy of the PPHI,
            - (ii) to request rectification or erasure;
            - (iii) to restrict the processing of PPHI;
            - (iv) if applicable, to data portability.
            - To make such a request, please contact support staff at 1-866-MEDIORB or support@mediorbis.com. MediOrbis and The MSMD Network will consider and act upon any request in accordance with applicable data protection laws.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the encounter (s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Signature: _____ **Date:** _____