Consent to use electronic communications

Videoconferencing – (Skype/Facetime- telemedicine)

Physician Information:

Dr. Lawrence Kobetz
849 Upper Wentworth St. Suite 409
Hamilton, L9A 5H4
Telephone: 905 574 4767
Fax: 905 383 8733

The physician has ordered to communicate using the following means of electronic communication
(The services) Videoconferencing – (Skype/Facetime- telemedicine)

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge and understand and that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with physician or the physician's staff using the services may not be encrypted. Despite this, I agree to communicate with the physician or the physician's staff using these services with the full understanding of the risk.

I acknowledge that either I or the physician may, at any time withdraw the option of communication electronically through services upon providing written notice. I also acknowledge that I have the right to refuse signing this form.

PATIENT INFORMATION:

Patient Name: _____ D.O.B: _____

Phone: _____ Email: _____

Address: _____ Skype name: _____

Patient signature; _____ Date: _____

Witness signature: _____ Date: _____