Grace Medical Services, LLC

Authorization for Telehealth Medicine

This form allows the practice listed above to send records on your behalf.

Client Name: Date of Birth:

Email: Phone #:

Telehealth allows providers to utilize interactive audio, video or data communication regarding my treatment. I hereby consent to participating in medical or Psychiatric services (hereinafter referred to Grace Medical Services LLC) via telephone or the internet (hereinafter referred to as Telehealth) with the Medical Provider (hereinafter referred to Grace Medical) listed above:

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person medical or psychiatric services. Any information disclosed by me during my treatment, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including, but not limited to mandatory reporting of child, elder, and dependent adult abuse, self-harm, and any threats of violence I may make towards a reasonably identifiable person, I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my provider has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while medical Services has been found to be beneficial for some diagnosed with severe physical and/or mental disorders, there is no guarantee that all services of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our sessions or other communication by my provider to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person services and that if my provider believes I would be better served by another form of these services, such as in-person sessions, I will be seen in person by my current provider or reassigned to a different provider that can provide such services. I have been advised that a screenshot of the phone call or call log from my provider's phone will be provided to Grace Medical Services LLC for potential audits of services provided and will be maintained in the medical record.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my services answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to prepare to Change.

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I understand that telehealth is the temporary authorization of telehealth service delivery by Governor Larry Hogan and the State of Maryland Department of Health, in an ongoing effort to mitigate possible spread of Novel Corona virus ("Covid-19") under Executive Order No. 20-03-20-01 and may be rescinded at any time by the State of Maryland and/or Governor Hogan, which would reinstate the condition of "in-person" services.

My signature below indicates that I have read this Agreement and agree to its terms. ***Additionally, I give explicit consent to Grace Medical Services and the assigned provider to provide telehealth services for delivery of medical or Psychiatric services.*** Furthermore, Grace Medical Services, LLC, has explicitly informed me that, by choosing to receive medical services by using "audio-only" telehealth or "video calling" telehealth, on any available platform which is not HIPPA compliant

will be at my own risk as Grace Medical Services LLC cannot guarantee the confidentiality of transmission for these services. I understand that Grace Medical Services LLC will take all available precautions to protect my privacy within normal limits, and will continue to abide by HIPPA privacy guidelines, but due to the possibility of telehealth related privacy breaches, by knowingly engaging in these services where delivery of sensitive health related information is shared; I am fully aware of the privacy risks associated with telehealth and I am knowingly and explicitly consenting to telehealth delivery of Medical or Psychiatric services and agree Grace Medical Services LLC will not be held liable for privacy breaches due to telehealth transmission of private information.

I give consent for the following methods of communication in reference to my treatment form GMS to the listed email address and telephone contact information which may include appointment reminders and medication information.

( ) Text Messages

( ) Voice Mail Messages

( ) Audio calls and voicemails

( ) Email

_____	_____	_____
Participant Signature	Date	Witnessed by
_____	_____	
Printed Name of Participant	Phone number	