

Colorado Center for Arthritis and Osteoporosis  
Consent for Treatment via Telehealth

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

By signing below, I consent to receiving medical services via telehealth. Telehealth is a technology similar to Skype, but it is secure and HIPAA-compliant. We use a service called doxy.me.

I understand that I retain the option to refuse the delivery of the services via telemedicine at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program or insurance benefits to which I would otherwise be entitled.

I understand that all applicable confidentiality protections shall apply to the services

I understand that I shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date