SUNSHINE WELLNESS, LLC
Mental & Sexual Health
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Telemedicine Consent Form

I hereby consent to engaging in telemedicine with Sunshine Wellness LLC as part of my behavioral health and sexual health treatment. Telemedicine may include the practice of psychotherapy, diagnosis, treatment (including the prescribing and managing of psychiatric medications), and the transfer of medical data using interactive audio, video, or data communications.

1. My Rights

- I understand that I may revoke my consent to telemedicine at any time by providing written notice.
- The laws that protect the confidentiality of my medical information also apply to telemedicine. Information I disclose during the course of my treatment is confidential, except in situations where disclosure is required or permitted by law.

2. Limits to Confidentiality

I understand that confidentiality may be broken under the following circumstances, including but not limited to:

- Suspected child, elder, or dependent adult abuse
- Expressed threats of violence toward an identifiable victim
- When I make my mental or emotional state an issue in a legal proceeding

3. Risks of Telemedicine

I understand that there are risks and consequences to telemedicine, including but not limited to:

- Technical failures that disrupt or distort the transmission of medical information
- Unauthorized access to medical information during transmission
- Unauthorized access to the electronic storage of medical information despite reasonable safeguards

4. Acknowledgment

I have read and understood the information above. I have had the opportunity to discuss this consent with a staff member of Sunshine Wellness LLC and have had my questions answered. I voluntarily consent to telemedicine services as part of my care.

Print Name Signature

Date: _____