CYNTHIA M. GOODMAN, M.D., INC.
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# TELEHEALTH AUTHORIZATION AND RELEASE

I hereby consent to communicating by cell, e-mail and online with Dr. Cynthia Goodman and her staff and personnel (hereinafter referred to collectively as "my Doctor") so as to conduct virtual consultations, telemedicine/telehealth, and any other purpose deemed by my Doctor to be appropriate while I am receiving medical and aesthetic services.

As announced by the US Department of Health & Human Services ("HHS") on March 17, 2020, I understand my Doctor is now authorized to use non-public facing audio and/or video communication technology to provide telehealth, whether or not related to COVID-19, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, but my Doctor is not authorized to use public facing technology, such as Facebook Live, Twitch or TikTok. I accept that even authorized non-public facing third-party applications potentially introduce privacy risks, but my Doctor will enable all available encryption and privacy modes when using these applications.

I also agree that my Doctor may communicate with me by the following additional methods:

Cell # (calls and texts) (____)_____ E-mail _____

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. Unless and until I revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from any telehealth medical privacy claims I might otherwise have had prior to HHS's March 17, 2020 notification. I certify that I have read this Authorization and Release and fully understand its terms.

_____ _____
*Patient Signature* *Witness/Physician/Staff*

_____ _____
Patient Name Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

_____ _____
*Parent/Guardian/Conservator Signature* Date

_____
Parent/Guardian/Conservator Name

Please email this form to
info@sfbayplasticsurgery.com