

Telehealth Consent Form

PATIENT INFORMATION

Name: _____ Age: _____
Gender: _____ Date of birth: _____ dd / mm / yyyy

I hereby consent to receive healthcare services through telemedicine or telehealth platforms provided by . These services may include video conferencing, audio communication, and/or other secure electronic methods to connect me with my healthcare provider.

ACKNOWLEDGMENT OF BENEFITS AND LIMITATIONS

I understand that telehealth services offer several benefits, including: Improved access to healthcare services, Reduced travel time and associated costs. I also acknowledge the following limitations: Lack of a physical examination, which may impact diagnostic accuracy, Possible challenges with the quality and security of electronic communication, Potential risks of technical difficulties or interruption

PRIVACY AND SECURITY

I understand that my healthcare provider will take all reasonable measures to protect the privacy and security of my personal and medical information. However, I acknowledge that electronic communications carry inherent risks, including the potential for unauthorized access, interception, or disclosure of my information.

RIGHT TO WITHDRAW OR MODIFY CONSENT

I understand that: I have the right to withdraw my consent for telehealth services at any time without affecting my right to future care. I may request an in-person visit with my healthcare provider instead of telehealth services. My healthcare provider reserves the right to discontinue telehealth services if they believe it is not in my best interest.

DOCUMENTATION AND RECORD-KEEPING

I understand that my telehealth visit will be documented, and my medical records will be maintained in accordance with state and federal regulations. I acknowledge that, if necessary, my information may be shared with other healthcare providers to ensure continuity of care.

ACKNOWLEDGMENT AND SIGNATURE

By signing below, I confirm that I have read and fully understand this Telehealth Consent Form. I agree to receive healthcare services through telehealth platforms under the terms outlined above.

Signature: _____
Date: _____ dd / mm / yyyy