

Telemedicine Consent and Insurance Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Insurance Information

Insurance Provider

Insurance ID Number

Group Number

Subscriber Name

Telemedicine Consent

I understand that telemedicine involves the use of electronic communications to enable health care providers to share medical information for the purpose of improving patient care. I understand that I have the following rights:

- Confidentiality of my health information
- To withdraw my consent at any time

☐ I have read and agree to the Telemedicine Consent

Signature

Patient/Guardian Signature

Date