Telehealth Consent Form

Please read the information below carefully and fill out the required fields to consent to telehealth services.

Client Information

Full Name

Date of Birth

Address

Provider Information

Provider Name

Practice/Clinic Name

Consent to Telehealth Services

By signing this form, you acknowledge that:

- You understand the nature and purpose of telehealth services.
- You understand the risks and limitations associated with telehealth.
- You have the right to withdraw consent at any time.

Questions or Concerns

Signature

Client Signature

Date