Telemedicine Consent Form

Patient Information

Name:

Date of Birth:

Contact Information:

Telemedicine Services

I understand that telemedicine involves the use of audio, video, or other electronic communications to interact with my healthcare provider, for diagnosis, consultation, treatment, and/or education.

Consent Acknowledgement

I acknowledge that I have read and understood the information provided regarding telemedicine services, including the risks and benefits, confidentiality, and my right to withdraw consent at any time.

Signature

Patient/Guardian Signature:

Date: