HIPAA Authorization for Telemedicine Services

Patient Name:

Date of Birth:

Purpose of Authorization

I authorize the use and disclosure of my protected health information (PHI) for the purposes of telemedicine services, including diagnosis, consultation, treatment, follow-up, and related healthcare management.

Information to be Disclosed

Recipient of Information

Name of Telemedicine Provider:

Facility/Organization (if applicable):

Expiration

This authorization will expire on (date or event):

Right to Revoke

I understand that I have the right to revoke this authorization at any time by providing written notice to the provider. Revocation will not affect any disclosures made prior to revocation.

Signature

Patient Signature:

Date:

Representative (if patient is under 18 or unable to sign):

Relationship to Patient:

Date: