Pre-Surgical Telehealth Consent Form

Patient Information

Full Name

Date of Birth

Email Address

Phone Number

Address

Surgical Procedure

Procedure Name

Scheduled Date

Telehealth Visit Details

Date of Telehealth Visit

Healthcare Provider

Consent Statements

☐ I understand the purpose, benefits, and alternatives to the proposed surgical procedure have been explained to me.

☐ I consent to discuss my pre-surgical assessment and instructions via telehealth.

☐ I understand the limitations and risks of telehealth compared to in-person visits.

- [ ] I acknowledge my privacy rights and the confidentiality of my medical records.
- [ ] I have had the opportunity to ask questions regarding my care and telehealth visit.

Additional Comments

Patient's Signature

Date