Rural Patient Telehealth Consent Agreement

Patient Information

Full Name

Date of Birth

Address

Agreement

I acknowledge and agree to participate in telehealth services provided by my healthcare provider. The purpose, benefits, and potential risks of telehealth have been explained to me, and I understand how telehealth sessions will be conducted.

- I have the right to withhold or withdraw consent to telehealth at any time.
- I understand that the laws protecting privacy and confidentiality of medical information also apply to telehealth.
- I understand all technology used will be secure and confidential to the extent possible.
- I may be responsible for co-payments or fees as explained by the provider.

☐ I have read and understand this agreement. I consent to participate in telehealth sessions.

Patient Signature

Date

Provider Signature

Date