Telemedicine Consent Form

Patient Information

Full Name

Date of Birth

Email Address

Phone Number

Consent Information

I consent to engaging in telemedicine with my healthcare provider. I understand that telemedicine involves the use of electronic communications to enable healthcare services at a distance.

- I understand the possible risks and benefits of telemedicine as explained to me.
- I have the right to withdraw consent to telemedicine at any time.
- I understand that my information will be kept confidential as required by law.

☐ I have read and understood the information above, and I give my consent to participate in telemedicine consultations.

Signature

Patient Signature

Date