

Pediatric Telehealth Consent Form

Patient Information

Child's Name

Date of Birth

Parent/Guardian Name

Contact Phone

Contact Email

Consent to Telehealth Services

I understand that telehealth involves the use of electronic communications to enable health care services to continue without in-person appointments. Potential benefits, risks, and alternatives have been explained to me as outlined in the practice's Telehealth Policy.

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I consent to the use of telehealth for my child's health care services.

Confidentiality

I understand that reasonable and appropriate efforts will be made to protect the confidentiality of my child's telehealth session, as required by law.

Right to Withdraw

I understand that I may withdraw my consent for telehealth at any time without affecting my future care or treatment.

Parent/Guardian Signature

Date