Telemedicine Informed Consent Form

Patient Information

Patient Full Name

Date of Birth

Email Address

Phone Number

Consent to Telemedicine

☐ **I understand the risks and benefits of telemedicine.**

☐ **I consent to receive health services via telemedicine.**

Confidentiality

☐ **I understand that my privacy will be protected during telemedicine sessions.**

Patient Rights

☐ **I have the right to withdraw consent at any time.**

Questions or Concerns

List any questions or concerns:

Signature

Patient Signature

Date