Teledermatology Consent Form

Patient Information

Full Name:

Date of Birth:

Introduction

You are being asked to participate in a teledermatology consultation. The purpose of this form is to obtain your consent for this service.

Information to be Shared

- Medical records and images related to your skin condition may be shared with your dermatologist via electronic communication.

Consent

- You understand that teledermatology involves the exchange of medical information electronically.
- You can withdraw consent at any time without affecting your care.
- There may be limitations due to the lack of physical examination.
- Your privacy will be protected in accordance with applicable laws.

Patient Agreement

☐ I have read and understood the information above and consent to the use of teledermatology services.

Signature:

Date: