# Telemedicine Data Privacy Consent Form

## Patient Details

Full Name

Date of Birth

Contact Number

## Information

This form is intended to inform you about how your personal and medical information will be collected, used, stored, and protected during your participation in telemedicine consultations.

## Consent

- I understand that my health information will be collected, recorded, and retained as part of my telemedicine consultation.
- I understand that my data will be kept confidential and secured in compliance with applicable privacy laws.
- I am aware that my data may be shared with healthcare providers involved in my care.
- I am informed about the possible risks associated with electronic transmission of health information.
- I understand I may withdraw my consent for data processing at any time by notifying the healthcare provider.

☐ I have read and understood the above information and consent to the collection, use, and sharing of my data for telemedicine services.

## Additional Notes or Questions

Patient Signature

Date

Provider/Witness Signature

Date