Electronic Consent for Medical Teleconsultation

Patient Information

Full Name

Date of Birth

Email Address

Teleconsultation Details

Healthcare Provider Name

Consultation Date

Consent Statement

I understand that my healthcare provider will use teleconsultation technology to provide medical care and advice. I acknowledge that teleconsultation may involve technical limitations and that all confidentiality and privacy rules apply.

I consent to participate in electronic medical teleconsultation and understand the scope, possible risks, and benefits.

☐ I have read and agree to the terms above.

Electronic Signature

Date Signed