Telehealth Consent Form

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Informed Consent for Telehealth Services

I, [Insert Patient Name], hereby consent to participate in telehealth services with [Practitioner Name] for the purpose of receiving medical consultation, evaluation, and treatment.

Telehealth Services

Telehealth includes the use of electronic communications to enable health care providers to deliver services to patients without an in-person visit.

Privacy and Confidentiality

Your privacy is important to us. All telehealth communications will be conducted in a secure environment using [insert technology used]. Personal health information will be protected in accordance with HIPAA regulations.

Potential Risks

As with any communication method, there are potential risks, including but not limited to: technology failure, unauthorized access, and possible lack of adequate physical examination.

Agreement

By signing below, I confirm that I have read and understood the information provided above, and I consent to the use of telehealth services.

_____ **Signature**

_____ **Date**

Contact Information

If you have any questions or concerns, please contact us at:

Email: [Insert Email]

Phone: [Insert Phone Number]