

## TELEMEDICINE CONSENT FORM

Patient Information		
First Name	Last Name	Date of Birth

I, , hereby consent to participate in telemedicine consultations with for the purpose of receiving medical care and advice.

I understand that telemedicine involves the use of electronic communications to enable healthcare providers to remotely diagnose, consult, treat, and educate patients. This may include, but is not limited to, video conferencing, telephone conversations, secure messaging platforms, and the electronic transmission of medical records and images.

I acknowledge that telemedicine consultations have potential benefits, including increased access to medical care, reduced travel time and costs, and the ability to consult with healthcare providers from the comfort of my own location. However, I also understand that there are potential risks and limitations associated with telemedicine, including:

- Limited access to my complete medical records and physical examinations, which may impact the accuracy of diagnoses and treatment recommendations.
- Technology failures or interruptions during the consultation, which could affect the quality of care.
- Risks associated with the electronic transmission of personal health information, despite reasonable efforts to secure the communication channels.
- The possibility of misunderstandings or miscommunications due to the lack of non-verbal cues and in-person interactions.

I understand that I have the right to refuse or terminate telemedicine services at any time and that alternative forms of medical care may be available to me. I also acknowledge that my healthcare provider has the right to determine whether telemedicine is appropriate for my specific medical condition and needs.

I agree to participate in telemedicine consultations with under these terms and conditions. I understand that the same confidentiality and privacy protections that apply to in-person medical consultations also apply to telemedicine consultations.

I hereby release , its affiliates, officers, employees, and agents from any and all claims, liabilities, or damages arising from or in connection with the use of telemedicine services, except those resulting from gross negligence or willful misconduct.

I have had the opportunity to ask questions and have received satisfactory answers regarding the nature and risks of telemedicine. By signing below, I indicate my understanding of and consent to participate in telemedicine consultations with .

**Signature:**

**Signature Date:**