# Consent to Teleconsultation Services Form

Patient Name

Date of Birth

Email

## Purpose

I hereby consent to engage in teleconsultation with my healthcare provider. I understand that teleconsultation involves the use of audio, video, or other electronic communications to interact with my provider.

## Potential Benefits & Risks

- Increased access to medical care.
- Convenience in scheduling and attendance.
- Potential limitations due to technology or inability to examine in person.
- Possibility of incomplete transmission of information.

## Confidentiality

Reasonable and appropriate efforts have been made to protect the security and confidentiality of teleconsultation data. I understand all confidentiality protections under law apply to teleconsultation.

## Patient's Consent

☐ I have read and understood the information above and consent to participate in teleconsultation services.

☐ I understand that I can withdraw my consent at any time, without affecting my future care or services.

Questions or Concerns

Type here...

Patient Signature

Date