Patient Approval for Remote Healthcare Assessment

Patient Information

Full Name

Date of Birth

Contact Information

Remote Assessment Details

Date of Assessment

Healthcare Provider

Approval Declaration

I hereby give my approval and informed consent to participate in a remote healthcare assessment conducted by the healthcare provider mentioned above. I understand the nature and scope of the remote assessment, and I acknowledge that I have been provided with information regarding the process, benefits, and possible limitations. I willingly choose to proceed with remote care.

Patient Signature

Date