Patient Authorization for Video Medical Consultation

I, the undersigned patient, authorize my healthcare provider to conduct a video medical consultation for the purposes of diagnosis and treatment.

Information

- I understand that a video consultation means I will be remotely connected with my healthcare provider using secure video technology.
- This consultation will be subject to the same confidentiality and privacy laws as a face-to-face visit.
- I understand that technical problems or disruptions may occur during the video consultation.
- I may withdraw my consent to video consultation at any time before or during the session.
- Alternative options (such as in-person appointments) have been explained to me.

By signing below, I confirm that I have read and understood the above information, and consent to participate in a video medical consultation.

Patient Name:

Date of Birth:

Signature:

Enter full name

Date:

Parent/Guardian Name (if patient is under 18):