Remote Medical Consultation Authorization

Patient Information

Patient Name:

Date of Birth:

Contact Number:

Medical Practitioner Information

Practitioner Name:

License Number:

Contact Information:

Consultation Details

Date of Consultation:

Type of Consultation:

Purpose/Reason:

Authorization & Consent

☐ I authorize the above healthcare provider to conduct a remote consultation and provide medical advice or treatment as required.

☐ I acknowledge that remote consultations may have limitations compared to in-person visits and have had the opportunity to ask questions.

☐ I provide my informed consent for the remote consultation as described above.

Patient (or Legal Guardian) Signature

Date