Telehealth Service Consent Record

Patient Information

Full Name

Date of Birth

Contact Number

Email

Telehealth Service Details

Provider Name

Date of Telehealth Session

Type of Service

Consent Confirmation

☐ I have read and understand the information regarding telehealth services and consent to receive care through telehealth.

☐ I understand that privacy and security measures are in place, but there may be risks to confidentiality.

Additional Comments

Signatures

Patient Signature

Date:

Provider Signature

Date: