Virtual Healthcare Consultation Permission Form

Patient Information

Full Name

Date of Birth

Phone Number

Email Address

Consent

- [ ] I allow healthcare providers to conduct my consultation via virtual platforms.
- [ ] I understand the risks, limitations, and privacy policies regarding virtual healthcare services.
- [ ] I give permission for communication and sharing of medical information as necessary for my care.

Comments or Questions

Optional

Patient Signature

Date

Parent/Guardian Signature (If minor)

Date