# Telehealth Consent Form

**Purpose:** This form is intended to obtain informed consent from a patient to participate in healthcare services provided via telehealth technologies. Telehealth allows patients to consult healthcare providers remotely using video conferencing, audio communication, and digital transmission of medical information.

## Patient Information

**Full Name:** {fullName}

**Date of Birth:** {dateOfBirth}

**Address:** {address}

**Phone Number:** {phoneNumber}

**Email:** {email}

## Telehealth Description

Telehealth involves the use of electronic communications to enable healthcare providers to evaluate, diagnose and treat patients remotely. Services may include:

{#telehealthServices}

* {service}

{/telehealthServices}

## Consent Terms

* I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider to deliver services to a patient when they are located at a different site.
* I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.
* I understand that I have the right to withhold or withdraw my consent to the use of telehealth at any time, without affecting my right to future care or treatment.
* I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed.

## Risks and Limitations

Potential risks associated with the use of telehealth include, but may not be limited to:

{#telehealthRisks}

* {risk}

{/telehealthRisks}

## Patient Attestation

By signing this form, I acknowledge and agree to the following:

* I have read this form and had an opportunity to ask questions.
* My questions have been answered to my satisfaction.
* I consent to receive healthcare services via telehealth from {providerName} and affiliated healthcare professionals.

## Insurance Details

{#hasInsurance}

**Insurance Provider:** {insuranceProvider}

**Policy Number:** {policyNumber}

{/hasInsurance}

{^hasInsurance}

The patient has indicated that they do not currently have health insurance coverage.

{/hasInsurance}

## Emergency Contact

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Phone Number** |
| {#emergencyContacts}{name} | {relationship} | {phoneNumber}{/emergencyContacts} |

## Signature

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** {signatureDate}

**Provider Name:** {providerName}

*Note: A copy of this signed consent form will be provided to the patient upon request.*