



Informed Consent for Telehealth Services

- I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location.
- I understand that the telehealth visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information, including HIPPA, also apply to telemedicine.
- I understand that I will be responsible for any co-payments or coinsurances that apply to my telemedicine visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without effecting my right to future care or treatment.
- I understand that by signing this form I am consenting to receive health care services via telehealth.

Patient Name
(Printed)

Date of Birth

Patient Signature

Date