Patient Telehealth Consent Form

I have read and understood the Telehealth Patient Information Form.

I agree to have video consultations with: _____

(Name of Doctor, Health Care Provider, Or Service)

Name: _____

Signature: _____ **Date:** / /

Consent for Recording Video or Images

I agree to have this video consultation recorded, or to have photographs taken if required. This material will be sent and stored securely and only used to benefit my healthcare.
I have the right to see the video or images if desired.

Name: _____

Signature: _____ **Date:** / /