

Telemedicine Participation Agreement

Patient Name:

Date of Birth:

Agreement Terms

1. I understand that telemedicine involves an electronic communication of my medical information to practitioners who may be located in different areas.
2. I consent to participate in telemedicine consultations and understand the potential risks and benefits.
3. I may stop telemedicine consults at any time and request in-person services.

Consent

☐ I have read and agree to the terms above.

Signature:

Date:

Submit Agreement