

Consent Form for Remote Clinical Services

I hereby consent to participate in remote clinical services provided by [Provider Name]. I understand that remote services are delivered via secure video, phone, or online platforms. I understand the risks, benefits, and alternatives to remote services, and that my participation is voluntary.

Full Name:

Date of Birth:

Email Address:

Phone Number:

By signing below, I acknowledge that I have read and understand this consent form, and I agree to participate in remote clinical services.

Signature:

Date:

Submit