Clinic Name

TELEMEDICINE PATIENT CONSENT FORM

- I agree to participate in telemedicine visits. By signing this agreement, I authorize the electronic transmission of my medical information so that it can be received via telephone or videoconference by a doctor and/or persons involved in my medical or mental health care.

  Yes_____ No_____

- I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations in order to sufficiently address my health concerns.
- I understand that I can withdraw my permission for telemedicine at any time, and that if I choose to do so, no action will be taken against me, and I may still pursue a face-to-face consultation with the same doctor or other health professional.
- I understand that my doctor(s) at _____ are following the recommendations put forth by the American Medical Association regarding telemedicine consultations, and that these guidelines can be accessed at www.americantelemed.org.
- I understand the above information and I consent to telemedicine consultation.*

  Yes_____ No_____

PATIENT SIGNATURE_____ Date _____