TELEMEDICINE CONSENT FORM

PURPOSE: The purpose of "Telemedicine Consent Form" is to get the patient's consent in order to participate in appointments of telemedicine care.

RECORDS: Telecommunications with patients will not be recorded and stored. The dentist will store and will view your health information (ex: x-rays, photographs, digital impressions etc) to evaluate your condition at a later time.

TELEMEDICINE INFORMATION: The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with video and audio.

ACCESS: The patient accepts that he/she needs access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telemedicine appointment.

PATIENT RIGHTS: The patient can withdraw his/her consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

Patient Name

First Name Last Name

Email

example@example.com

By signing this form,

I understand that all the laws that are protecting my privacy of medical history or information are also applied to telemedicine practices.

I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures.

I understand that I can be charged the additional fees that my insurance does not cover.

I accept that I authorize the use of telemedicine for my treatment and diagnosis.

Signature of Patient or Guardian

Date

Month Day Year

Print Name