TELEHEALTH CONSENT FORM

Patient Name: _____
Date of Birth: _____ **Phone:** _____
Email Address: _____

The purpose of this consent form is to obtain your consent in order for you, the patient, to participate in telehealth sessions with your provider. By signing this consent form, you agree to participate in telehealth appointments with Top Medical Group.

All existing laws regarding your access to treatment information apply during telehealth appointments. The telehealth appointments will not be recorded or stored. Reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telehealth services and all existing confidentiality protections under federal and state laws apply to information disclosed in all telehealth sessions.

The system that will be used during telehealth appointments is in compliance with HOPAA, however, it is your responsibility as the patient to be in a private environment in order to ensure that your information is protected.

The provider has the right to refuse completing the telehealth appointment if he/she feels the surrounding environment is not appropriate for the appointment or private enough in order to protect the privacy of the patient.

I, _____, choose to engage in telehealth sessions. By signing this form, I certify that I have read or had this form explained to me, agree to participate via a HIPAA-compliant telehealth platform, and agree to abide by the rules identified in this form.

Patient Signature: _____ **Date:** _____