

**Patient Consent Form for a Telehealth**

**Consult/Video Visit**

|  |  |  |
| --- | --- | --- |
| I, | Click or tap here to enter text. | have been provided with |
|  | *Full Name of Patient* |  |
| information on Telehealth Consults/Video visits. |  |
| The information was provided in written form |[ ]
| My health worker, nurse or doctor discussed this information with me verbally |[ ]
| I understand the information that has been provided to me |[ ]
| Including: |  |
| * I understand that a video visit is a choice
 |[ ]
| * I was provided with an option for a face to face visit as well
 |[ ]
| * I chose to do a video visit
 |[ ]
| I was told about: |  |
| * Why my doctor thought video visits may benefit me
 |[ ]
| * The video visit may help my health service provide better services to me
 |[ ]
| * There may be some technical problems including video or sound difficulties
 |[ ]
| * While the video system meets standards to protect my privacy and security, this is not a guarantee against someone hacking or tapping in, but this is a low risk.
 |[ ]
| * My health service and the pharmacist may need to transfer files securely
 |[ ]
| I can change my mind at any time and stop using video visits, including in the middle of a visit |[ ]
| This will not make any difference to my right to ask for and receive healthcare. |[ ]
| I agree to have video visits with |  |
| Click or tap here to enter text. |  |
| Name of Doctor, other health care provider or service |  |
|  |  |
| Click or tap here to enter text. |  | Click or tap to enter a date. |
| Patient Signature |  | Date |