

## Consent Form for Telehealth Consultation

### Patient Information:

- **Name:**
- **Date of Birth:**
- **Referred By:** /ref/
- **Contact Information:**
  - **Phone Number:**
  - **Email Address:**

### Consent to Telehealth Services

I, , hereby consent to receive telehealth services from DoctorAI.

I understand that telehealth services involve the delivery of healthcare services using electronic communications and technology.

I understand and agree to the following:

1. **Privacy and Security:** I understand that my health information will be protected in accordance with applicable laws and regulations.
2. **Limitations of Telehealth:** I understand that telehealth services may have limitations compared to in-person visits, and that there may be delays in receiving care in emergency situations.
3. **Emergency Care:** I understand that if I experience a medical emergency, I should call 911 or go to the nearest emergency room.
4. **Communication:** I understand that communication with the healthcare provider may be limited to electronic means, such as video conferencing or phone calls.
5. **Remote Monitoring:** I understand that the healthcare provider may use remote monitoring devices to collect health information.

I have read and understood the information above and consent to receive telehealth services from AI Doctor.

**Patient Signature:**

**Date:**