

Consent Form for Telehealth Consultation

Patient Information:

- Name:
- Date of Birth:
- Contact Information:

o Phone Number:

o Email Address:

Consent to Telehealth Services

I, [Patient's Name], hereby consent to receive telehealth services from [AI Doctor Application Name].

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: /sn1/

Date: