Authorization and Consent to Participate in Telehealth Consultation

Patient Name: _____ Patient ID #:_____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s):

_____(**Please write/type in Specialty you are seeing**)

2. **NATURE OF TELEHEALTH CONSULTATION**: During the telehealth consultation:

a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of digital images, email, and/or audio video communications.
b. Physical examination may take place
c. Video and/or photo recordings may be taken of the procedure(s)

3. **MEDICAL INFORMATION AND RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Additionally, dissemination of any patient identifiable images or other information from this telehealth interaction shall not occur without your consent.

4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and California law apply to information disclosed during this telehealth consultation.

5. **RIGHTS**: You may withhold or withdraw consent to the telehealth consultation at any time before or during the consultation without affecting the right to future care or treatment.

6. **DISPUTES:** I agree that any disputes I may have with any medical provider arising from this telehealth consultation will be resolved in California and that California law shall apply to any such disputes.

7. **RISKS, CONSEQUENCES AND BENEFITS**: I have been advised of all the potential risks, consequences and benefits of telehealth. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

_____	_____	_____
Patient/Legal Representative	Relationship	Date
_____		_____
Witness		Date