**Patient Information:**

1. **Full Legal Name:** [Patient's Full Legal Name]
2. **Date of Birth:** [Patient's Date of Birth]
3. **Address:** [Patient's Address]
4. **Email Address:** [Patient's Email Address]
5. **Phone Number:** [Patient's Phone Number]

**Provider Information:**

1. **Healthcare Provider Name:** [Provider's Full Legal Name]
2. **Provider's License Number:** [Provider's License Number]
3. **Contact Information:** [Provider's Phone Number and Email Address]

**Telemedicine Services:**

1. **Description of Telemedicine Services:**
   * [Describe the telemedicine services to be provided]
2. **Nature of Telemedicine Services:**

* [Explain the limitations and benefits of telemedicine services]

**Patient Consent:**

I, the undersigned patient, hereby consent to participate in telemedicine services provided by [Provider's Full Legal Name]. I understand and agree to the following:

1. **Purpose of Telemedicine Services:**
   * Telemedicine services are being provided for the purpose of medical evaluation, diagnosis, consultation, treatment, and other related healthcare services.
2. **Potential Risks:**
   * I understand that there are potential risks associated with telemedicine, including but not limited to technology failures, security breaches, and disruptions in the communication link.
3. **Privacy and Security:**
   * I acknowledge that the telemedicine platform used will adhere to privacy and security standards, and my medical information will be kept confidential to the extent required by law.
4. **Alternatives:**
   * I understand that I have the right to seek in-person medical services, and I have been informed of alternatives to telemedicine.
5. **No Guarantee of Treatment:**
   * I acknowledge that telemedicine services do not guarantee treatment success and that outcomes may vary.
6. **Emergency Situations:**
   * In case of a medical emergency, I understand that I should call emergency services (911 or local emergency number) immediately.

**Patient Acknowledgment:**

I have had the opportunity to ask questions and discuss any concerns regarding telemedicine services. I understand and agree to the terms outlined in this telemedicine consent form.

**Patient's Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** [Date]

**Provider Acknowledgment:**

I, the undersigned healthcare provider, confirm that I have explained the nature of telemedicine services to the patient and have addressed any questions or concerns they may have had.

**Provider's Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** [Date]