Telehealth Consultation Consent

Affix ID Label Here	MRN			
Surname	Given Names			
Address - Street	Suburb	Postcode		
Date of Birth	Sex	AMO		
Hospital Name	Ward			

The procedure for conducting the telehealth consultation has been fully explained to me and I understand that:

- My participation is completely voluntary and I have the right to refuse to participate
- I have the right to withdraw my consent and terminate the consultation at any time
- Health professionals are permitted to take notes during the consultation
- I agree to my medical information being used for case conference, ensuring that my right to confidentiality is maintained

- I agree to my personal and health information relevant to the telehealth service to be shared by all health practitioners involved in delivering the program.

My consent relates to:

- ☐ ***A single telehealth session***
- ☐ ***An episode of care involving several telehealth sessions***
- ☐ ***The use of medical information for case conference***

Please tick the appropriate response

For patient over 16 years

Patient Name:_____

Signature of Patient:_____

(Print)

Date :_____

For patient under 16 years/ in Care / with Guardian

Parent / Carer / Guardian Name:_____

(Print)

BINDING MARGIN - NO WRITING
FILE IN HEALTH RECORD

Reorder information

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