Telemedicine Consent:

Patient Name: ____________________ Date of Birth: ___________

Date: ________________

Provider: ____

Telemedicine allows you to receive healthcare services using live two-way audio and/or video communications. It may include:

- Patient history review Evaluation, diagnosis, and treatment Electronic prescribing

Washington law recognizes telemedicine as equivalent to in-person care when delivered appropriately and securely.

Patient Acknowledgments: I understand that:

- Nature of Telemedicine: My healthcare provider will evaluate, diagnose, and treat my condition through electronic communication, which may not be the same as an in-person visit.
- Technology: Secure and HIPAA-compliant platforms will be used. However, there is a small risk of data breach or technical failure.
- Limitations: Not all conditions are suitable for telemedicine. I may be advised to seek in-person care or go to an emergency department if appropriate.
- Privacy & Security: Washington State and federal laws protect the privacy of my medical information. No recordings will be made without my explicit consent.
- Billing: My telemedicine visits may be billed to my insurance as allowed by Washington State law. I may be responsible for co-pays, deductibles, or non-covered services.
- Audio-only: I consent to audio-only (telephone) consultations when video is unavailable, as allowed under Washington State law.
- Right to Withdraw: I may withdraw my consent at any time without affecting my right to future care or treatment.

Consent Statement

I confirm that I have read or had this form read to me and understand the risks, benefits, and limitations of telemedicine. I Voluntarily agree to participate in telemedicine services with my healthcare provider.

Patient Signature: _______________________________ Date: _____________

Parent/Guardian (if minor): ________________________ Date: ____________