



## NRC DNP Telehealth LLC

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### Telehealth Patient Consent Form

**PURPOSE:** The purpose of "Telemedicine Consent Form" is to get the patient's consent in order to participate in appointments of telemedicine (audio/video) cares.

**RECORDS:** Audio/video telecommunications with patients will not be recorded and stored. Patients' medical information obtained by the diagnosis and analysis can be used anonymously for further improvements in scientific studies, and my information will be kept private

**TELEMEDICINE INFORMATION:** The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with video and audio.

**ACCESS:** The patient accepts that he/she needs access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telemedicine appointment.

**PATIENT RIGHTS:** The patient can withdraw his/her consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

#### Patient Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

#### Guardian Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

#### By signing this form,

I understand that all the laws that are protecting my privacy of medical history or information are also applied to telemedicine practices.

I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures.

I understand that I can be charged the additional fees that my insurance does not cover.

I accept that I authorize health care professionals to use telemedicine for my treatment and diagnosis.

I agree to terms & conditions

Date \_\_\_\_\_

Signature \_\_\_\_\_