HARBOR PHYSICIANS
Primary Care & Internal Medicine
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TELEHEALTH CONSENT FORM (Required for Telehealth Visits)

Patient Information

Name: _____ DOB: _____

Consent

I consent to receive healthcare via telehealth (video, audio, or secure electronic communication).
I understand telehealth may be used for evaluation, diagnosis, treatment, and follow-up care, but does not replace all in-person visits.
My provider may require an in-person visit if medically necessary.

Florida Compliance

I understand my provider is licensed in Florida and provides telehealth under Florida Statutes §456.47.
Telehealth services meet the same standard of care as in-person services when clinically appropriate.
Some services, prescriptions, or medications may be limited by Florida law or clinical judgment.

Risks

I understand risks include:

- Technical failure or interruption
- Limited physical examination
- Possible delays in care
- Rare privacy/security risk

Privacy

My information is protected under HIPAA and Florida law, but no electronic system is 100% secure.

Patient Rights

I may refuse or stop telehealth at any time and request in-person care when available.

Emergency Notice

Telehealth is not for emergencies. Call 911 or go to ER if needed.

Consent Statement

I understand and voluntarily agree to telehealth services.

Patient: _____ Signature: _____
Date: _____