TELEHEALTH CONSULTATION CONSENT FORM

Full name		DOB	
Phone Number		Suburb & Post code	
Email address:			
Medicare Number:		Medicare Indiv reference number:	
DVA Card number (if relevant):		DVA Card type (if relevant):	

I understand:

- My participation is voluntary.
- I have the right to withdraw my consent and cease consultations at any stage.
- The procedure for conducting telehealth consultations.
- The health provider will take notes during the consultation.
- My referring doctor and/or healthcare team may be contacted in reference to my treatments.

My consent relates to:

- A period of care which may involve several consultations via telehealth.
- The notes taken as a requirement by the funding body for my appointments are done so privately and stored within a secure platform.
- The sharing of information in relation to my treatment is to be sent to the nominated email address, which is a secure and safe address that only I have access.
- Permission for additional specified health professionals to be contacted in reference to my treatments.

I declare that all information provided on this form is true and accurate at the time of signing and that my identity is that stated on this form.

If client not in care:

Client Name (Print): _____

Signature of Client: _____

Date: _____

For client in care:

Carers Name (Print): _____

Signature of Carer: _____

Date: _____

Client has no access to email so verbal consent of client was taken via phone by:

Provider name: _____ Provider type: _____

Date: _____