21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
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GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

6540 Park Ave,
Allen Park, MI 48101
(313) 381-2528

TELEHEALTH SERVICES CONSENT FORM

I, ____________________________________ (patient name), agree to participate in telehealth services with ____ (provider name) for my endocrine care.

By signing this form, I understand and agree with the following:

1. Telehealth involves using electronic communications to enable healthcare providers to share my- medical information for improving my care.
2. The potential benefits of telehealth include improved access to endocrine care and more efficient evaluation and management of my condition.
3. Possible risks include:
   - Incomplete physical assessment due to the limitations of audio/video conferencing
   - Technical difficulties or interruptions in the audio/video connection
   - Potential for unauthorized access to the telehealth session
4. I have the right to withhold or withdraw my consent for telehealth services at any time without affecting my right to future care.
5. The same confidentiality protections that apply to in-person visits also apply to telehealth services.
6. Telehealth is not appropriate for urgent or emergency situations. In case of an emergency, I should call 911 or go to the nearest emergency room.
7. I am responsible for ensuring privacy at the end of telehealth communication.
8. My healthcare provider will determine if tele-health is appropriate for my endocrine condition and may require an in-person visit if necessary.
9. I consent to the use of telehealth in my medical care and treatment related to my endocrine condition.

Patient Signature ________________________ Date ________________

If Individual is unable to sign this Authorization, please complete the information below

Name of Guardian __________________________________

Legal Relationship__________________________________

Representative Signature: __________________________ Date: ________________