Telehealth Consent Form

JIAO FENG CLINIC
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I consent to participate in telehealth services with Jiao Feng Clinic. I understand that:

1. Telehealth involves electronic communication of my personal medical information.
2. I may experience technical difficulties.
3. I can withdraw my consent at any time.
4. All applicable privacy laws (including HIPAA) apply to telehealth visits.

I understand the risks and benefits and agree to participate.

Signature: _____ Date: _____
Patient Name: _____ DOB: _____