



TELEHEALTH CONSENT FORM

I agree to receive health care services via telehealth. I understand that:

- I have the right to access Medi-Cal covered services through an in-person, face-to-face visit or through telehealth.
- The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.
- Medi-Cal provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.

There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit. For example, technical glitches, disconnection, compromised privacy/security, etc.

I have read this document carefully and understand the potential limitations and risks of receiving services via telehealth, and have had my questions answered to my satisfaction.

Client Number: _____

Client: (print) _____ (sign) _____ Date: _____

Witness: (print) _____ (sign) _____ Date: _____

Parent/Guardian/
Conservator: (print) _____ (sign) _____ Date: _____