Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Virtual Consultation Consent Form

Patient Full Name: ______________________________ DOB(YYYY/MM/DD)__________________

Service being Provided: ___________________ Practitioner Name:___________________________

Emergency Contact. ____

Email: ___________________________________ Cell:__________________________________

Date of Virtual Consultation:_______________________________________

I/We have requested or agreed to a consultation/meeting with Visionary Health Medical Educational Clinic practitioner/clinician through audio-visual communication technology a video software which is in compliance with the practitioner's /clinician's association or college. It is further understood that The Health Insurance Portability and Accountability Act and supplemental legislation collectively referred to as the HIPAA rules (HIPAA) lay out privacy and security standards that protect the confidentiality of protected health information (PHI) of the client/patient and that the guidelines are followed.

Visionary Health Medical Educational Clinic (VHMEC) has advised that it cannot guarantee the security of such software and notwithstanding this advice, as services can be performed offsite. I/We hereby acknowledge and accept the risks associated with communicating by such electronic means and authorize VHMEC to communicate with me/us in this manner.

I/We further acknowledge that any document communication by me/us during the virtual consultation shall be stored/uploaded after each session.

The virtual consultation documentation follows all appropriate requirements, all legally binding and shall be deemed to be hereby signed in agreement.

Client/Patient NAME:______________________ Signature:______________________

Clinic Practitioner: ______________________
Signature