



ALAKANANDA DUTT

MD Psychiatry (PGIMER, Chandigarh)

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☎ 9831070821 (For Emergency : 8PM - 9PM)

☎ 9831400821 (For Appointment : Monday - Saturday, 11am - 5pm)

● Reg No : 59842 of WBMC

Authorization Letter

I am _____, D/O / S/O

_____ would like to state that, I have understood the information provided regarding telemedicine. I hereby give my informed consent for the use of telepsychiatry consultation in my mental health care. At present, I am located at _____.

I understand that I have the right to withhold or withdraw my consent to the use of tele-medicine in the course of my care at any time, without affecting my right to future care or treatment.

I hereby authorize _____, D/O / S/o _____ and related to me as _____ (relationship) to represent me.

He/she will represent and participate in my mental healthcare through telemedicine in the course of my diagnosis and treatment. I understand and accept that there are risks and benefits in assigning a representative for my mental healthcare

Date :

Signature of patient & Date

Date :

Signature of Family Member & Date