UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME &MR#

OFFICE OF TELEMEDICINE

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

I understand that my health professional, _____ (LIP Name & Credentials) wishes for me to participate, as a patient, in a Telemedicine consultation at UVA Health.

I understand that:

1. my health care professional and I will communicate by interactive video conferencing with physicians and health care professionals at UVA Health; and/or
2. digital images of my medical condition will be made and sent to physicians and other health care professionals at UVA Health for evaluation and consultation with my health care professional; and/or
3. it is the role of my health practitioner to determine whether or not the condition being diagnosed, type of activities permitted using telemedicine services, and/or treated is appropriate for a telemedicine encounter; and/or
4. appropriate security measures have been taken with telemedicine services but risks to privacy still exist notwithstanding such measures; and/or
5. my health care professional shall be held harmless for any information lost due to technical difficulties.

By signing this consent, I authorize my health professional to release any relevant medical information, pertaining to my medical condition and medical care, to UVA Health, its physicians and health care professionals. I also authorize the Medical Center, or its physicians, to release any and all information to my insurance company or any other agent which may be responsible for paying my medical bills. I have read this document carefully, and hereby consent to participate in the Telemedicine consultation under the terms described above.

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	DATE	TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO THE PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 7. Other Blood Relative

☐ 2. Guardian ☐ 5. Parent ☐ 8. **Other****

☐ 3. Husband/Wife ☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement

Requires review and appointment by Ethics Consult Service. See Medical Center Policy 0024, Informed Consent.

PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	**DATE**	**TIME**

SIGNATURE OF WITNESS (OPTIONAL) **REQUIRED FOR TELEPHONE CONSENTS**	PRINTED NAME	**DATE**	**TIME**

INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	**DATE**	**TIME**