OFFICE OF TELEMEDICINE
CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

I understand that my health professional wishes for me to participate, as a patient, in a Telemedicine consultation at the University of Virginia Health System.

I understand that:
1. my health care professional and I will communicate by interactive video conferencing with physicians and health care professionals at the University of Virginia Health System; and / or
2. digital images of my medical condition will be made and sent to physicians and other health care professionals at the University of Virginia Health System for evaluation and consultation with my health care professional.

By signing this consent, I authorize my health professional to release any relevant medical information, pertaining to my medical condition and medical care, to the University of Virginia Health System, 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.

_________________________ ___________________________ ___________________________
Patient's Signature Print Patient's Name Date

The above release is given on behalf of ___________________________ (patient's name) because the patient is a minor or has been determined to be incompetent to give medical consent.

_________________________ ___________________________ ___________________________
Signature of Parent/ Legal Guardian Relationship to Patient Date

INTERPRETER ATTESTATION (when applicable):
I have provided translation to the person(s) whose signature(s) is affixed above.

_________________________ ___________________________
Interpreter's Signature Date

Fax to UVA Telemedicine: 434-244-7521