UNIVERSITY OF VIRGINIA HEALTH SYSTEM

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 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