

**CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION**

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

I understand that as a participating patient, my physician and I will communicate by interactive television (videoconferencing) with physicians and health care professionals at the University of Virginia Health System.

By signing this consent, I authorize my physician to release any relevant medical information, pertaining to my medical condition and medical care, to the University of Virginia Health System, its physicians and healthcare 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 further understand and consent to being interviewed, taped, filmed or photographed by my physician and/or the University of Virginia Health System.

Any interview, tape, film or photograph made of me will be used for medical purposes and maintained by the University of Virginia Health System as confidential medical records, consistent with Virginia and Federal Law.

I have read this document carefully, and hereby consent to participate in the Telemedicine consultation under the terms described above.

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Patient's Signature

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Print Patient's Name

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Date

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Witness' Signature

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Print Witness' Name

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Date

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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.

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Signature of Parent/Legal Guardian

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Relationship to Patient

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Date