UNIVERSITY HEALTH SERVICES
MARY B. COBURN HEALTH & WELLNESS CENTER *at* FSU

Greetings FSU Parents,

Please see attached page two for Consent to Treat Authorization for patients under the age of 18. Once you have read through and signed the document, please e-mail a copy to the Medical Records Department. Once the document has been added to your student's chart, they will be able to use the services offered at UHS.

If you have any questions, please contact the Medical Records Department and they will direct you to the correct department that will assist you.

Medical Records Contact:

850-644-5523

Uhs-medicalrecords@fsu.edu

960 Learning Way, P.O. Box 3064178, Tallahassee, FL 32306-4178
850.644.6230 • Fax 850.644.1491 • www.uhs.fsu.edu

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Informed Consent for Telemedicine Consultation

Patient Name_____ Date of Birth_____

1. I am currently physically in the State of Florida and wish to engage in a telemedicine consultation with a provider from University Health Services (UHS).
2. The UHS healthcare provider has explained how the video conferencing technology will be used for this consultation and that it will not be the same as a traditional visit with a healthcare provider since we will not be in the same room.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
4. I understand that the UHS healthcare provider or I can discontinue the telemedicine consult if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand my healthcare information may be used by UHS for scheduling and billing purposes.
6. I understand my UHS healthcare provider will conduct the telemedicine consult in an area that is private in order to protect my healthcare information.
7. I have had the limitations of and alternatives to a telemedicine consultation explained to me.
8. I acknowledge that no guarantees have been made to me as to the effect of diagnosis and treatment through telemedicine.
9. I have read and had my questions answered regarding items 1-8 above.
10. I understand the risks and benefits of a telemedicine consultation and wish to proceed.

Signature of Patient or Parent/Guardian if under the age of 18_____

Printed Name_____Date_____

3/2020

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