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

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

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