Consent for Telehealth Consultation and Treatment

To better serve the needs of people throughout our region, some health care services are now available by two-way interactive video communications and/or by the electronic transmission of information, which may assist in the evaluation and treatment of health care problems. Referred to as “telemedicine” or “telehealth” this means that I may be evaluated and treated by a provider at the University of Utah (University Provider) by telemedicine from Salt Lake City, Utah. Since this may be different than the type of consultation with which I am familiar, I understand and agree to the following:

1. The University Provider may be at a different location from me. A physician or other provider (“local provider”) may be at my location with me to assist in the consultation. Consultation may also take place at my home without a local provider present.
2. The telemedicine process may consist of transmission of video or digital photographs of me, or of transmission of x-rays, test results, or details of my medical record. These will be transmitted to and discussed with the University Provider.
3. Information transferred electronically may be more vulnerable to disclosure or tampering than information transferred by other means.
4. In an emergent situation either the University provider or my local provider will determine/direct who will be present during the telemedicine consultation.
5. In a non-emergent situation I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the University Provider and Local Provider. I will give my verbal permission prior to additional personnel being present.
6. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording. Video recordings and other data, including x-rays, images, and photos may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes, including performance improvement.
7. The University provider will obtain additional consent if use of compact disc recordings and other data, including x-rays, images, and photos is desired for any other purpose.
8. The local provider, if present and the University Provider will keep a written record of the consultation in my medical record.
9. I understand that my participation in telemedicine is voluntary. I have the right to
   A. Refuse the telemedicine consultation, or stop participation at any time.
   B. Limit the physical examination during the consultation.
   C. Request that the local provider refrain from transmitting information if I make the request before the information is transmitted
   D. Request that nonmedical personnel leave the room or be denied permission to view the telemedicine consultation at any time.
   E. Request to consult privately with the University Provider at any time.
10. This signed consent form is valid for three years.

I acknowledge the nature of my condition and the nature and purpose of the proposed telemedicine procedures and any substantial and significant risks of serious harm together with their alternative methods of treatment or non-treatment, have been explained to my satisfaction. I acknowledge/understand the attendant risks involved and voluntarily assume them in the hopes of obtaining the desired beneficial results. I acknowledge/understand that all claims for negligence and other claims against the University of Utah and its employees and agents, including physicians, nurses, technicians, and students may be governed by the provisions of the Utah Governmental Immunity Act, Utah Code Annotated Section 63G-7-101 et seq., as may be amended from time to time, a special law restricting how and when a claim must be presented and limitations on the amount recovered.

Signature of Patient: ___________________________ Date: __________
Patient Representative: ___________________________ Date: __________
   (if patient unable to sign)
Witness: ___________________________ Date: __________

Patient Name: ___________________________
(please print)
Local Provider: ___________________________
Location: ___________________________

Please FAX signed form to (801) ___________ and place original in patient’s record.
Confidential: This material is prepared pursuant to Utah Code Annotated § 26-25-1 et seq., for the purpose of evaluating health care rendered by hospitals or physicians and is not part of the medical record. It is also classified as “protected” under the Government Records Access and Management Act, Utah Code Annotated § 63G-2-101 et seq.