UVA Health

POPULATION HEALTH DEPARTMENT

CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

I have requested that I take part in a telehealth appointment with the following provider:
_____(Name & Credentials).

I understand that:

1. my provider and I will communicate by interactive video conferencing for assessment and/or short-term counseling purposes;
2. it is my responsibility to ensure I have a private and confidential space in order to participate;
3. it is the role of my provider to determine whether or not the assessment, counseling or services rendered are appropriate for a telehealth encounter; if not, we would reschedule the session by phone or in person;
4. appropriate security measures have been taken with telehealth services but risks to privacy still exist notwithstanding such measures;
5. my provider shall be held harmless for any information lost due to technical difficulties;
6. the information I provide may only be shared with other individuals at Population Health for scheduling purposes;
7. the alternatives to a telehealth appointment/consultation have been explained to me.

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and my questions have all been answered.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	DATE	TIME

To be completed by Population Health - No signature was obtained due to impracticality or verbal consent given:

SIGNATURE OF POPULATION HEALTH PROVIDER	PRINTED NAME	DATE	TIME