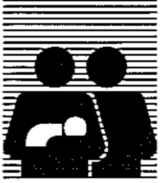

HIGHLAND FAMILY PRACTICE
4460 South Highland Dr., Suite 400
Salt Lake City, Utah 84124
801-272-4111

TELEMEDICINE PATIENT CONSENT FORM

I, *(name of patient or legal guardian)* _____________________________________, agree to participate in a telemedicine evaluation for myself, or for a telemedicine evaluation for ________________________________, for whom I am a legal guardian. By signing this agreement, I authorize the electronic transmission of my medical information and/or video conference session so that it can be viewed by a medical provider and other persons involved in my medical care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that, as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a medical provider in person.

____ ____________________

(signature of patient or legal guardian) *(date of signature)*

Printed with FinePrint trial version - purchase at www.fineprint.com