Informed Consent for Telehealth Consultation

Student Name_____ Date of Birth_____

1. I am currently physically in the State of Pennsylvania and wish to engage in a telehealth consultation with a provider from the Student Health Center.

2. The SHC 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 SHC healthcare provider or I can discontinue the telehealth consult if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand my healthcare information may be used for the SHC for scheduling and billing purposes.

6. I understand my SHC healthcare provider will conduct the telehealth 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 telehealth consultation explained to me.

8. I acknowledge that no guarantees have been made to me as to the effect of diagnosis and treatment though 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 Student or Parent/Guardian if under the age of 18_____

Printed Name_____Date_____

5/18/20 dw