



COMMUNITY-UNIVERSITY HEALTH CARE CENTER

UNIVERSITY OF MINNESOTA

Driven to Discover®

First and Last Name/Patient Label

Consent for Telemedicine

Community-University Health Care Center (CUHCC) uses telemedicine to provide patients with greater access to care.

Telemedicine (includes but not limited to Telehealth/Telepsychiatry/Teledentistry) is the use of electronic communications to allow health care providers and patients to share information when they are at different locations. Telemedicine may be practiced using phone calls, audio communication software, and/or video communication software. If you will be using your cell phone, message and data rates may apply.

Your consent to telemedicine is voluntary. You can withdraw your consent to telemedicine at any time. If you choose not to consent to telemedicine, or if you withdraw your consent in the future, you can access CUHCC services by scheduling an appointment for an in-office visit by calling 612-301-3433

The laws that protect the confidentiality of your personal information also apply to telemedicine. Your rights and our responsibilities regarding your information are described in our Notice of Privacy Practices. You may always request a copy of our Notice of Privacy Practices.

Telemedicine Limitations:

- Some conditions cannot be diagnosed or treated via telemedicine. Your provider may determine that a condition is not appropriate for telemedicine and will communicate this to you and explain alternative options.
- Telemedicine requires the digital communication of your information. CUHCC has put in place protocols and procedures to comply with privacy and security requirements with regards to these digital communications. Nevertheless, digital communications carry privacy and security risks. It is possible that these protocols and procedures could fail, causing unintended disclosures of your information.

Patient Consent:

I have read and understand this “Consent for Telemedicine.” I have discussed all questions I had with CUHCC staff and all my questions have been answered to my satisfaction. I authorize the use of telemedicine using the methods mentioned in this document for the course of my treatment with CUHCC.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE (MONTH/DAY/YEAR)

IF YOU ARE A LEGAL REPRESENTATIVE, WHAT IS YOUR RELATIONSHIP TO PATIENT (PARENT, GUARDIAN, ETC.)