MINOR CONSENT TO PARTICIPATE IN
TELEMEDICINE CONSULTATION/ TREATMENT

AUTHORIZATION FOR TELEHEALTH TREATMENT:

- I authorized and voluntary consent to the participation of this telehealth consultation to assess and treat my child’s medical condition(s).

- The physician, physician assistant and nurse practitioners (Providers) will not be at the same location as my child during the telehealth consultation, and they will not have the opportunity to perform an in-person physical examination. It is my responsibility to provide information about my child’s medical history, condition, and care that is complete and accurate. Providers will rely on the information that I provide, and they will not be responsible for any advice, recommendations, and/or decisions based on incomplete or inaccurate information provided by on behalf of my child.

- I will be informed at the start of a telehealth consultation if anyone is in the room or on the line with the Provider. I have the right to exclude any such person(s) from participating in the telehealth consultation.

- There are numerous risks associated with transmitting information over the Internet and using telecommunication technologies for telehealth services, including electronic tampering and unauthorized access by third parties. To help maintain the confidentiality of telehealth consultations, I should only use a computer or device that I know is safe and, at a minimum, has a firewall, anti-virus software installed, is password-protected, and accesses the Internet through a private, password-protected connection.

- I should only receive the telehealth services in a private setting and take all reasonable precautions (such as lowering my voice and distancing myself from others) to help maintain confidentiality.

- Delays in medical evaluation or treatment could result from technical deficiencies or failures of the telecommunications technology used to provide the telehealth services. In the event that the telehealth services are unavailable or interrupted, Providers may implement alternative means of communication or recommend an in-person medical evaluation.

- The use of video technology to deliver healthcare may not be equivalent to direct patient to physician contact. If Providers determine that the telehealth services do not adequately address my medical needs, they may recommend an in-person medical evaluation or refer my child to an outside provider.

- I have the right to withhold or withdraw my consent to the use of telehealth services at any time without affecting my child’s receipt of future care or treatment.

- In the case of a medical emergency, dial 911 or go to the nearest hospital.
• I understand I can make a complaint of my child’s provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353 or contacting the Director of the Student Health Center.

2. ACKNOWLEDGEMENT OF OUTPATIENT TREATMENT:

I hereby understand and agree that the medical care, which may be furnished to my child in the UTD Student Health Service, will be limited solely to outpatient treatment. I understand and agree that my child may be released before all of their medical problems are known or treated and that it will be necessary for me to make arrangements for my child’s follow-up care.

3. RELEASE OF INFORMATION:

I hereby consent to the release of my child’s medical information to authorized UTD Student Health Service staff, Counseling Center staff, and consulting physicians, including those seen in the Health Center and/or those seen on a referral basis from the Health Center, also including hospital Emergency Rooms and medical personnel with ambulance services.

4. ACKNOWLEDGEMENT OF REFERRAL SERVICES:

I hereby understand and agree that my child’s medical care and/or treatment deemed necessary for the undersigned may involve referral to specialty physicians, Emergency Rooms, X-ray facilities, or other providers outside the UTD Health Center, and that any and all expenses for referral services are the responsibility of the patient.

5. ACKNOWLEDGE BEING INFORMED ABOUT THE NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have been informed about the NOTICE OF PRIVACY PRACTICES of the UTD Student Health Service. This information describes how my child’s medical information may be used and disclosed and how I may have access to the information. HIPAA Privacy Rules require that we furnish you with the notice.

6. ACKNOWLEDGEMENT OF LOCATION

I acknowledge that my child must be in the State of Texas in order to complete any telehealth visit.

____________________________________________    _______________________________    ___________
Signature of Parent/Authorized Person                  Relationship                       Date

__________________________________________________
Print Name of Parent/Authorized Person

_______________________________________________    _________________________
Signature of Witness                                      Date