

# University Family Medicine Center PA

407-679-4800

## Telehealth Consent Form (Florida-Compliant)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Provider Name: University Family Medicine Center – Corey Burns, DO, Sheryl Frost, APRN, Sarah Norman, APRN, Ronald Burns, DO

Date of Consent: \_\_\_\_\_

### 1. Nature of Telehealth Services

- I understand that telehealth involves the delivery of health care services using electronic communications, information technology, or other means between a healthcare provider and a patient who are not in the same physical location.
- I understand that telehealth may include consultation, diagnosis, treatment, follow-up, and/or education.

### 2. Technology and Limitations

- I understand that telehealth may use secure video, audio, and/or data communication.
- I acknowledge that there are limitations to telehealth, including possible incomplete transfer of information (e.g., physical exam limitations).
- I understand that in-person care may be required if telehealth is not sufficient for my condition.

### 3. Confidentiality and Privacy

- I understand that the laws protecting the confidentiality of medical information also apply to telehealth.
- I acknowledge that all patient information will be documented in my medical record, consistent with Florida Statute 456.47.
- I understand that despite reasonable efforts, security protocols could fail, and confidentiality could be compromised

### 4. Risks and Benefits

- Potential benefits include greater access, reduced travel, and continuity of care.
- Potential risks include technical difficulties, data breaches, misdiagnosis, or delays

### 5. Consent to Treatment

- I understand I have the right to refuse or discontinue telehealth at any time without affecting my future care or treatment.
- I have had an opportunity to ask questions and understand that I may request in-person services when available.

### 6. Patient Consent Statement

I consent to receive telehealth services under the terms described above.

I consent to audio-only services if video is unavailable (when appropriate and permitted by law).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_