CONSENT: I voluntarily request Texas Tech University Health Sciences Center and Doctors(s)__________________________ and such associates, technical assistants and other health care providers as they may deem necessary (“TTUHSC Telemedicine Consultants”) to participate in my medical care through telemedicine consultation. I understand that telemedicine consultation includes interactive audio, video or other electronic media. I further understand that TTUHSC is a teaching institution and I agree to be a part of the teaching programs.

I understand that TTUHSC Telemedicine Consultants practice in a different location than my primary health care provider, do not have the opportunity to meet me face-to-face or perform a physical examination, and must rely on information provided by me and my on-site health care providers. I acknowledge that TTUHSC Telemedicine Consultants cannot be held liable for advice, recommendations and/or decisions based on factors not within their control such as incomplete or inaccurate data provided by others or distortions of diagnostic images or specimens that may result from electronic transmission.

I further acknowledge that my primary health care provider remains in charge of my medical care and is not obligated to comply with the advice, recommendations and/or decisions of TTUHSC Telemedicine Consultants. I understand that no warranties or guarantees are made to me as to result or cure. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. It is also my responsibility to comply with instructions I receive from my health care providers and to report deviations from such instructions to my health care providers in a timely manner.

To enable TTUHSC Telemedicine Consultants' participation in my care, I voluntarily request and authorize the disclosure of all or any part of my medical record (including oral information) to TTUHSC Telemedicine Consultants by my on-site health care providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment and related information; 2) drug screen results and information about drug and alcohol use and treatment; and 3) mental health information.

I understand that the disclosure of my medical information to TTUHSC Telemedicine Consultants, including the audio and/or video consultation, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and confidentiality may be compromised by illegal or improper tampering.

I consent and authorize TTUHSC Telemedicine Consultants to audio record, video record, and/or still photograph the consultation. I understand that any or all parts of my body may be included in these visual displays and that this permission includes visual recording of surgical procedures. I agree that these recordings will remain the property of TTUHSC Telemedicine Consultants and may or may not become part of the medical record. I understand that this telemedicine consultation may be viewed by certain medical and non-medical persons for informational, research, and educational purposes. These visual displays may be published in professional journals, books, presentations, and other similar activities in the interest of medical and telemedicine education, knowledge, and research. I waive any and all rights, compensation, royalties, or other payment in connection with the use of videotapes, photographs, and images. I further understand that any photographs and videotapes become the property of Texas Tech University Health Sciences Center and may be used without any further authorization or notice to me. I also understand that the images may be used in a manner that may or may not identify me by name. I also relinquish any right to inspect photographs and videotapes.

I agree that this consent will be valid and remain in effect: (circle one)
   a. as long as I attend the ___________________________Clinic
   b. during my current hospitalization
   c. specify other time limit: _____________________________

RELEASE OF INFORMATION: TTUHSC Telemedicine Consultants may disclose all or any part of my medical record (including oral information) and may provide bills/invoices to: 1) any person, corporation or agency/or their authorized representative) which is or may be liable under a contract to TTUHSC, or to me or my family members for all or part of the telemedicine consultation charges including, but not limited to, hospital or medical service companies, insurance or third party payers, workers’ compensation carriers, or my employer; and 2) any individual or entity designated by me as a guarantor or party responsible for payment of fees for health care services provided to me.

I understand that I may revoke this authorization for the release of information at any time, by providing written notice to TTUHSC Center for Telemedicine except to the extent that action has been taken in reliance on it.
Unless earlier revoked, this authorization expires automatically ninety (90) days from the date signed or ninety (90) days after the last consult or after all insurance or third party claims have been paid or satisfactorily resolved, whichever occurs last.

**RELEASE FROM LIABILITY:** I release and agree to hold harmless TTUHSC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand TTUHSC cannot be responsible for use or redisclosure of information by third parties.

**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services including telemedicine consults otherwise payable to me to TTUHSC physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services including telemedicine consults not covered by or which exceed the amount estimated to be paid or actually paid by my insurance company or third party payer and agree to make payment as requested by TTUHSC.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

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Signature of Patient/other Legally Authorized Person

Signature of Witness or Translator*

Print Patient Name/
or any other Legally Authorized Person

Print Name of Witness or Translator

Date Time Translated Language (If not English)

REVISED: 7-24-00