University of Colorado Hospital
UNIVERSITY OF COLORADO HEALTH

TELEMEDICINE CONSENT FORM

I have requested that University of Colorado Hospital Authority ("UCH"), arrange a telemedical consult for me regarding the condition described below with a physician employed by a University Physicians Incorporated ("UPI"). Via this consult, UCH will provide me with the conclusions of the UPI physician. The UPI physician will reach those conclusions based solely on the information provided by me or my physician to UCH. Neither UCH, UPI nor any of their affiliates (collectively, the "University of Colorado Medical Center") shall have any liability or responsibility for the accuracy or completeness of that information or for any errors in its transmission.

By providing the UPI physician's conclusions, the University of Colorado Medical Center Parties to do not assume any continuing responsibility for my medical care or treatment. In addition, I recognize that, without a complete in-person physical examination, the UPI physician will be limited in his or her ability to correctly assess or diagnose my condition and recommend treatment.

Although the University of Colorado Medical Center Parties have no obligation to obtain additional medical records or any other information regarding my condition, I authorize my physician and any other person or entity to release any information pertaining to my health including health history, present complaints and laboratory and diagnostic data to any of the University of Colorado Medical Center Parties. The University of Colorado Medical Center Parties are authorized, at their election, to obtain any of such records and information.

For myself and my heirs, personal representatives, administrators, successors and assigns, I irrevocably release the University of Colorado Medical Center Parties and their insurers, officers, directors and employees from any and all known or unknown, foreseen or unforeseen, claims, actions or damages arising in connection with the consult or UPI physician's conclusions.

Patient's Current Diagnosis: _____

_____

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____