The University of the West Indies, St. Augustine Campus

**Health Services Unit**

**Telehealth Consent and Release Form**

1. I understand and acknowledge that The University of the West Indies (“the University”), Health Services Unit (“HSU”) uses the telehealth practice platform to gather general personal information and medical/health information from patients before scheduling and conducting e-visits and e-consultations with patients and for the purpose of evaluating, assessing and diagnosing the medical/health condition of patients (the “Permitted Use”). I therefore authorize the HSU to use the telehealth practice platform in my interaction with the HSU for the Permitted Use.
2. I understand that it is my responsibility to provide all necessary and accurate information pertaining to signs and symptoms, medical/health history, use of medication and my current condition to the healthcare professional(s) of the HSU in order for the HSU to be able to properly undertake the Permitted Use on my behalf.
3. As part of undertaking the Permitted Use on my behalf, I understand and agree that the HSU will need to collect and record my personal information and medical/health information and that same can be kept for further evaluation, analysis and documentation where appropriate, and in all of these situations, my personal and medical/health information will be kept private and will only be disclosed to medical and health professionals of the HSU who have a legitimate need to know.
4. I authorise the HSU to release my personal and medical/health information and/or records to authorised health service providers in circumstances where my health is, or may be in jeopardy and where due to ill health or injury, I may not have the capability to communicate my consent to the release of said information for preserving my life or safeguarding me from further injury. Accordingly, I release, indemnify and hold harmless the University and its officers, employees, agents, and servants of the HSU from any and all claims and/or liability arising from or in any way related to the dissemination of my personal and medical/health information and/or records to the above stated recipient(s) and/or for the Permitted Purpose.
5. I understand that during a telehealth session (e-visit/e-consultation) with the HSU, I will be contacted via videoconference software so that the HSU professionals can conduct interactive sessions with me; however, I understand that the telehealth session(s) can be conducted via regular video or audio calls if the technical requirements of the telehealth platform and accessibility cannot be met. I further acknowledge that in this type of platform, technical difficulties may happen which might cause a slight delay or need for rescheduling of my interaction with the HSU.
6. I understand that my current insurance may not cover fees related to the telehealth services provided by the HSU and I may be responsible for any costs that my insurance company does not cover.
7. I declare that this Consent and Release has been given by me voluntarily under no duress or threat of duress, without inducement, promise or guarantee being communicated to me.
8. I accept that I can withdraw this Consent and Release at any time and that while it may affect my access to the HSU’s telehealth services, it will not affect my situation when I need care in the future via the HSU.

Name

 I agree to the above terms and conditions

[Date]

[Signature]