AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

The purpose of this form is to obtain your consent to participate in a telehealth consultation with your provider.

Purpose and Benefits: The purpose of telehealth is to enable patients to get medical care without the inconvenience and expense of traveling to an office.

Nature of Telehealth Consultation: During the telehealth consultation:

- Details of you and/or your child's medical and nutritional history, examinations, x-rays, and tests will be discussed by interactive video, audio, and telecommunications technology.
- Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

Medical Information and Records:. All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Additionally, dissemination of any patient-identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation. All existing confidentiality protections under federal and Washington State law apply to information disclosed during this telehealth consultation.

Risks and Consequences: The telehealth consultation will be similar to a routine office visit, except interactive video technology will allow you to communicate with your provider at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to healthcare provider contact. Following the telehealth consultation, your provider may recommend a face-to-face visit for further evaluation.

Rights: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with your provider in person if you travel to his or her location.

Financial Agreement: You agree to contact your insurance company to determine your telehealth benefits. If you do not have telehealth benefits, you will be responsible for the full visit fee.

I have been advised of all the potential risks, consequences, and benefits of telehealth. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

_____
Patient Name (PRINT)

_____ _____
Patient/Representative signature Date

If signed by person other than patient, provide relationship to patient: _____