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Informed Consent for Telemedicine Services

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with the following providers:

Charlotte Davis, ANP, Caroline Hutto, CNM, Alana McLaughlin, ND, Amy Williamson, ND, Sara Wood, LPC, Laurie Hoyt, LCSW, and Suzette Mailloux, ND.

1) Purpose and Benefits. The purpose of this consent is to use telemedicine to enable patients to receive care during the COVID19 pandemic, and afterwards as needed.

2) Nature of Telemedicine Consultation. During the telemedicine consultation:

Details of you and/or your child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of HIPAA compliant interactive video, audio and telecommunications technology.

Physical examination of you or your child may take place.

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

4) Confidentiality. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Alaska state law apply to information disclosed during this telemedicine consultation.

5) Risks and Consequences. The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician 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 physician contact. Following the telemedicine consultation, your physician may recommend an in person visit or a visit to another provider.

6) Rights. You may withhold or withdraw consent to the telemedicine 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.

7) Financial Agreement. This telemedicine consultation will be billed to your insurance company or is payable with a same day cash discount.

I have been advised of all the potential risks, consequences and benefits of telemedicine. 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.

Signature _____ **Date** _____
Patient (or person authorized to give consent)

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

Signature _____ **Date** _____