BHRT & Integrative Wellness
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Informed Consent for Telemedicine Services

PATIENT NAME: (Please Print) DOB: _____	LOCATION of Patient: _____
PROVIDER NAME: Christine Kallander MSN, ANP PROVIDER LOCATION: Eagle River, AK. 99577	DATE CONSENT DISCUSSED: _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers and other practitioners at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, nutrition professionals, health coaches or other practitioners. The information may be used for health care delivery, diagnosis, therapy, consultation, transfer of medical data, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices, wearables, apps, and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home or work setting (or another remote site) while the provider obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management, but I also understand the telemedicine-based services may not be as complete as face-to-face service.
- Obtaining expertise of a distant specialist or care team member.

Please initial after reading this page: _____

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider and consultant(s);
- Delays in medical evaluation and treatment could occur due to technical problems occurring with information transmission and/or equipment failure, that could result in loss of information or delays in treatment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed without my consent.
- I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without affecting the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- I understand that I have the right to inspect all information recorded in my medical record in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained some alternatives to my satisfaction.
- I understand that telemedicine may involve electronic communication of my personal medical information to other practitioners who may be located in other areas, including out of state.
- I understand that it is my responsibility to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may benefit from the use of telemedicine in my medical care, but that results cannot be guaranteed or assured.

Please initial after reading this page: _____

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby assign to this practice any insurance or other third-party benefits available for health care services provided to me. I understand this practice has the right to refuse or accept assignment of such benefits. I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt. I consent to the forwarding of my information to a third-party as needed to receive payment for telemedicine services and I understand that existing confidentiality protections apply.

I give my consent to email or cellular telephone for appointment reminders and other healthcare communications. If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or cellphone I have provided.

I hereby authorize Christine Kallander MSN, ANP to use telemedicine in the course of my diagnosis, treatment, or medical other care.

Printed Name of Patient:

_____ *Date:* _____

Signature of Patient (or person authorized to sign for patient):

_____ *Date:* _____

If authorized signer, relationship to patient:

*Witness:*_____*Date:* _____

I have been offered a copy of this consent form (patient's initials) _____

Please initial after reading this page: _____