AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

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

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1) **Purpose and Benefits.** The purpose of this project is to use telemedicine to enable patients living in rural and/or underserved areas to get medical care by specialists without the inconvenience and expense of traveling to a city.

2) **Nature of Telemedicine Consultation**: During the telemedicine consultation:
   a) 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 interactive video, audio and telecommunications technology.
   b) Physical examination of you or your child may take place.
   c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

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 Washington 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 a visit to a Hospital in Seattle for further evaluation.

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. You have the option to consult with the specialist in person if you travel to his or her location.

7) Financial Agreement. This telemedicine consultation will be paid for by a grant from the federal government. You and/or your insurance company will not be billed for this visit.

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:_____

Witness:_____ **Date**:_____