

Frontier Health Services Informed Consent for Telemedicine Services

PATIENT NAME: _____ LEGAL GUARDIAN NAME: _____	PATIENT DATE OF BIRTH: _____/_____/_____ _____/_____/_____	TODAY'S DATE: _____/_____/_____ _____/_____/_____
PHYSICIAN NAME: DR. E DAVID HJELLEN CLINIC NAME: FRONTIER HEALTH SERVICES CLINIC LOCATION: 4325 LAUREL STREET SUITE 225, ANCHORAGE, AK 99508		

Introduction:

Telemedicine involves the use of electronic communications to enable your physician to meet with you at a separate location to continue ongoing medical care. The information discussed may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video

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. The telemedicine platform used by FHS is HIPAA Compliant and the protection of your personal health information is our utmost priority.

Expected Benefits:

- Alternate access to medical care by allowing a patient to remain within his/her home (or at a remote site) while still being able to meet directly with their physician.
- Increased access to medical evaluations and management during times of restricted mobility.
- The ability to maintain and adhere to the state mandated social distancing during the COVID-19 pandemic.

Possible Risks:

As with any medical treatment, 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 to allow for appropriate medical decision making by the physician and additional face-to-face visits may be required to effectively manage patient care.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the electronic equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. FHS will not record telemedicine sessions to provide additional safeguards against any such privacy breach.
 - FHS will not be able to manage the privacy and security of your environment while participating in a telemedicine appointment and request that you take all necessary precautions to protect your personal health information by securing your surroundings prior to your appointment.
- In rare cases, a lack of face-to-face treatment may result in judgment errors due to lack of environmental controls.

Please initial after reading this page: _____

By signing this form, I understand the following:

1. 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 to researchers or other entities without my consent.
2. I understand that I have the 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 care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction, and may receive copies of this information.
4. I understand that in person medical care may be available to me, and that I may choose to see the doctor face to face in lieu of telemedicine. I will, however, follow all Federal, CDC, State of Alaska and Municipality of Anchorage guidelines and mandates in regards to the containment of the COVID-19 Virus.
 - a. I understand that FHS reserves the right to refuse face-to-face services if myself or anyone I have been in close contact with has been/is currently ill or is experiencing symptoms of the COVID-19 virus.
 - b. I understand that in the event that any member of the FHS staff is ill or experiencing symptoms of the COVID-19 virus my regularly scheduled face-to face appointment may be moved to a telehealth appointment to maintain the health and safety of all patients.
5. I understand that I may still be expected to pick-up a hard copy of my medication prescription if the medication I am being prescribed is mandated by the DEA to be delivered direct to the pharmacy.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician 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 authorize Frontier Health Services and Dr. E David Hjellen to use telemedicine in the course of my diagnosis and treatment.

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

If authorized signer, relationship to patient: _____

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