Natural Family Medicine of Cascade Park, PC—Dr. Lori D. Brown
16701 SE McGillivray Blvd, #265, Vancouver, WA 98683; 360.882.1339

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Patient Name: ______________________________

1. **Purpose and Benefits**: The purpose of this telemedicine visit is to enable access to medical care during COVID-19.
2. **Nature of Telemedicine Consultation**: During the telemedicine consultation:
    a. Details of your and/or your child's medical history, examinations, imaging, and/or tests may be discussed.
    b. Physical examination of you or your child may take place.
    c. Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
3. **Medical Information and Records**: All existing laws regarding access to my medical information and copies of my medical records apply to this telemedicine consultation.
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. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties despite use of a HIPAA-compliant platform. My health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. The use of video technology to deliver healthcare and educational services may not be equivalent to direct patient-to-physician contact. Following the telemedicine consultation, your physician may recommend an office visit or urgent care visit or transport to ER for further evaluation.

By signing this form, I certify:

- That I have read and/or had this form explained to me,
- That I fully understand its contents including the risks and benefits of the telemedicine encounter,
- That I have been given ample opportunity to ask questions and that they have been answered to my satisfaction.

Patient's or Parent/Guardian's Signature: ______________________ Date: ____________

Witness Signature: ____ Date: ____________