

Alaska Psychiatric Outpatient Clinic

- 1) I understand that my local health care providers have requested that I be seen by a Consultant in Anchorage through the use of live video over a secure communication system. My health care providers have requested advice from a mental health specialist not available in my community.
- 2) I understand that my local health care providers and I will still make the decisions about what treatment I may or may not receive, and that this consultation with the Anchorage specialist is strictly to obtain and evaluation and recommendations for myself and my local health care providers to consider. I understand that any treatments with medications, etc will actually be provided to me by my local health care providers.
- 3) I understand that this type of video consultation (called "telemedicine") is a fairly recent way of delivering health care, and that there are some limitations compared with seeing a specialist in person. Those limitations are fairly minor depending on how good the sound and video are during the consultation with the specialist.
- 4) I understand that because this is a technologically based consultation, that sometimes it is necessary for a technician who works with the specialist in Anchorage to monitor the video to make sure the equipment is working properly. Such technicians will keep any information confidential.
- 5) I understand that this consultation is completely voluntary and that I can choose not to do it or not to answer questions at any time.
- 6) I understand that the Anchorage specialist can not physically examine me, nor physically intervene if needed for my health, and that only my local health care providers can provide such services to me.
- 7) I understand that none of the consultation will be recorded or photographed.
- 8) I consent to sharing electronically and otherwise my medical records between my local health care providers and the Anchorage specialist including: **(Initial each item you consent to)**
 - () my mental health records
 - () any health care records containing information about substance abuse
 - () health care records containing information about HIV or AIDS
 - () my medical health care records including but not limited to diagnostic testing, examinations, and medications.
 - () the medical record of this consultation
- 9) I understand that my local health care medical records will contain a copy of any medical records regarding this consultation, and that my local health care providers will work with me regarding the treatment plan for my mental health.
- 10) I understand that I will be informed and may decline to allow any one else to be present either here or at the Anchorage specialists location during this consultation. However, I understand that the specialist needs a health care person sitting in the room with me during the consultation to assist in the consultation and to help provide for continuity of care.
- 11) I understand that this video consultation is done over a secure communication system that is almost impossible for anyone else to access, but that since it is still a possibility, I accept the very rare risk that this could effect confidentiality.
- 12) I agree that I have had everything explained to me in a satisfactory manner and that all questions have been answered about the telemedicine encounter. I consent to the telemedicine encounter described above.

Signature: _____ Date: _____
(Patient/Legal Guardian)

Witness : _____

Please print:
Patient name: _____

Consent for a Telemedicine Consultation

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