REVOLUTION PSYCHIATRIC & ADDICTION TREATMENT

AUTHORIZATION *and* CONSENT *to* PARTICIPATE *in*

TELEMEDICINE CARE

Richard E. Repass, MD * Revolution Psychiatric and Addiction Treatment
2737 78th Avenue SE Suite 100 Mercer Island, WA 98040

The purpose of this form is to obtain your consent to participate in telemedicine consultation and care with *Dr. Richard Repass*.

1) **Purpose and Benefits.** While the broader purpose of this endeavor 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, it is in our current local and world contexts a more immediate necessity in providing care to the individual while remaining conscientious of the public health at large.

2) **Nature of Telemedicine Care**: During your telemedicine appointment with the doctor:
   a) Details of your medical history, examinations, x-rays, and tests will be discussed with you through the use of interactive video, audio and telecommunications technology.
   b) Physical examination of you may take place and in some circumstances (such as in the case of certain medications) may necessitate your taking your own blood pressure while on camera and/or other tasks of physical examination.

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 consultation, and just as in the case of an actual office visit, Dr. Repass may recommend a visit to a local hospital for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, at no risk of the loss or withdrawal of any program benefits to which you would otherwise be entitled.

7) **Financial Agreement.** Billing will be performed as per our Financial Policies and Procedures.

(Please Sign on the Following Page)

CONSENT TO PARTICIPATE in TELEMEDICINE CONSULTATION

By signing below, I consent to participating in telemedicine consultations between myself, _____ (name of patient), and Dr. Richard Repass. I have been advised of the potential risks, consequences and benefits of telemedicine. Dr. Repass 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.

_____ _____

Printed Name of Patient/Guardian Date

_____ _____

Signature of Patient/Guardian Email Address