I understand that I, or my ward, will be receiving medical services with a licensed health care provider. The purpose is to assess and treat health condition through an interactive video-conference.

I understand that:

1. I, my health care provider, or both of us will talk through the video-conference link with the clinician.
2. I can ask that the video-conference be stopped at any time. At any time, I can request to communicate with the clinician alone.
3. I understand that this session will be done through video-conference and that it substitutes for an in-person visit with the clinician. I understand services provided by the clinician will be billed to my insurer.
4. I understand that there are possible risks with the use of this technology. These are to include, but are not limited to:
    - Interruption of disconnection of the video-conference
    - A picture that is not clear enough to meet the needs of consultation
5. I authorize the release of any relevant medical information that pertains to me. This information may include my name, age, birth date, history, insurance/financial information or other healthcare information that is necessary to conduct this telehealth consultation. Dissemination of any patient identifiable images or information from the telehealth consultation to researchers or other entities shall not occur without written consent.
6. I understand that documentation of this consultation will become part of my medical record kept at St. Croix Health and that I will have access to all medical information resulting from the telehealth consultation as provided by law for patient access to my medical records. This consultation will not be otherwise recorded in any audio-visual format. All existing confidentiality protections shall apply to the telehealth consultation.
7. I understand that I must give my informed consent to participate in this service. I understand that I retain the option to refuse the telehealth consultation at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

I certify that this form has been fully explained to me. I have read it or have had it read to me and have had the opportunity to ask questions. I understand its contents. I give my consent and authorize the health care provider to conduct medical services. This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified.

Patient Name: _____ Date of Birth: _____
(Please Print)
Signature: _____ Date: _____