Name: ________________________________

CONSENT TO PARTICIPATE IN TELEMEDICINE APPOINTMENTS

1. **PURPOSE**. The purpose of this form is to obtain your consent for telemedicine appointments with a midwife. The purpose of these appointments is to assist in the ongoing evaluation of your pregnancy, your postpartum course, and/or your newborn during the COVID-19 pandemic that requires social distancing whenever possible.

2. **NATURE OF TELEMEDICINE CONSULTATION**. Telemedicine involves the use of audio, video or other electronic communications to interact with you and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine appointment, details of your medical history and personal health information may be discussed through the use of interactive video, audio and telecommunications technology. Additionally, video, audio, and/or photo recordings may be taken as needed for your medical record.

3. **RISKS, BENEFITS AND ALTERNATIVES**. The benefits of telemedicine include having access to your midwife without having to travel outside of your local community or even your home. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face appointment still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a midwife. If it is not safe or feasible for the midwife to provide a face-to-face visit, you may be referred to an alternative provider.

4. **STUDENT INVOLVEMENT IN TELEMEDICINE APPOINTMENTS**. ____________________________________ (practice name) participates in the clinical teaching of student midwives. During the COVID-19 pandemic, your midwife may also be training other health professionals to care for clients outside of the hospital setting. Midwifery students, students of other health care professions (i.e., nursing, physicians) and post-graduate fellows may participate in telemedicine appointment, under the supervision of the attending midwife, as part of the health care team, unless you do not consent. Additionally, it may be necessary for non-medical technical personnel to participate in the telemedicine appointment to aid in the audio/video link with the midwife.

5. **MEDICAL INFORMATION AND RECORDS**. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

6. **CONFIDENTIALITY**. All existing confidentiality protections under federal and Washington State law apply to information used or disclosed during your telemedicine appointment.

SAMPLE

7. **RIGHTS**. You may withhold or withdraw your consent to a telemedicine appointment at any time before and/or during the visit without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

My health care provider 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 have read and agreed to a telemedicine consultation.

_______________________________________ ____________________

Signature of Patient or Patient's Representative Date of Signing

____

Relationship of Representative to Patient

____

Signature of Witness (required if patient unable to sign)

REFUSAL: I refuse to participate in a telemedicine appointment as described above.

Signature: ______________________________________

SAMPLE