Lower Sioux Health Care Center
Telemedicine / Telehealth Consent Form (effective 3/27/20)

Due to the COVID-19 pandemic, I understand that my healthcare provider, Lower Sioux Health Care Center wholly owned by the Lower Sioux Indian Community in the State of Minnesota – a sovereign and federally recognized Indian tribe ("Center"), recommends that I have a telemedicine / telehealth appointment. This means that I and my healthcare provider or designee will, through interactive video connection and audio capabilities, be able to complete a visit with my healthcare provider electronically.

My healthcare provider has explained to me how the telehealth / telemedicine technology will be used during my appointment.

I understand there are potential risks with using technology:

1. The video or phone connection may not work or that it may stop working during the appointment.
2. The video picture phone connection or information transmitted may not be clear enough to be useful for the appointment.
3. My telemedicine / telehealth provider I may ask me to go to their office location if they feel the information obtained via telemedicine / telehealth was not sufficient to make a diagnosis.
4. Whenever possible, the electronic platform will be encrypted and HIPAA compliant, and my healthcare provider and their designee(s) will provide the service in a private setting. However, there may be certain circumstances that may arise when we would need to use other electronic platforms, however, we will ensure our communications are as safe as possible.

The benefit of a telehealth / telemedicine appointment are:

1. You may not need to travel as far to be seen.
2. You may be able to be seen sooner than waiting for a face-to-face appointment.
3. You will have access to a provider near your home.
4. You may save time and money spent on traveling.

I give my consent to have my appointment done by telehealth / telemedicine. I also understand other individuals may be present at the beginning of my appointment to operate the telemedicine equipment and that they will take all necessary steps to maintain confidentiality of the information obtained.

I understand that a limited physical examination may take place during the telemedicine appointment. I understand I have the right to ask my healthcare provider to discontinue my appointment at anytime.

I authorize the release of any relevant medical information about me to the healthcare provider, any staff the healthcare provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes.

I have read this document and understand the risk and benefits of the telehealth / telemedicine appointment via video or phone and have had my questions regarding the procedure explained. I hereby consent to participate in a telemedicine appointment under the conditions described in this document.

_____ _____ _____
Patient/legal representative signature Relationship Date

This is my electronic signature and by signing, I verify compliance and agreement to the above statement

_____ _____
Witness Date