TO BE COMPLETED BY MINOR PATIENT

Release of Protected Health Information for Minor Age 12-17yrs

I give permission for Dr Gilman and his staff to discuss my protected health information with a family member, caregiver or other person? _____YES _____NO

If yes, whom?_____ Relationship:_____

Phone#_____

Patient's phone number (not parent/guardian) :_____

Protected health information pertaining to HIV, Sexually Transmitted Diseases, Mental disorders, Drug and Alcohol abuse/rehab, or reproductive health will not be discussed with anyone other than the patient per office policy unless the patient is present.

MINOR PATIENT SIGNATURE: _____ DATE:_____

Informed Consent for Telemedicine Services

Patient Name:_____ Patient DOB:_____

Telemedicine is a way to get health care from home. Telemedicine visits let you and your provider meet by video, web portal, or other technology. This means that you will not be in the same room as your provider. A note about your visit will be placed in your health record and may be shared with others who are helping with scheduling or billing. **Our Providers are licensed for telemedicine services in Washington and Idaho. You must be physically located in Washington or Idaho during your telemedicine visit.**

You may stop the telemedicine visit at any time. Your provider may also stop the visit if they are worried about the connection quality or if they believe that you need to be seen in person.

Risks and other problems may occur such as equipment or internet failure or poor internet connection which could make it hard for the provider to see how you are doing and may result in more time before diagnosis and/or treatment.

Knowing the risks and benefits, I consent to Telemedicine Services with Gilman Family Practice. Depending on my coverage, I understand there may be a **copayment, deductible,** and **cost sharing** for Telemedicine Service. If I have any questions regarding coverage, I understand that it is my responsibility to contact my insurance provider and I agree to pay outstanding balances not covered by my insurance.

The consent is active for a period of one year from today.

_____

Printed Name if signing for the patient

_____ _____

Patient/Parent/Guardian Signature **Date**

**Telemedicine Services offered by Gilman Family Practice adhere to HIPAA Privacy and Security laws.*

GILMAN FAMILY PRACTICE (minor pt age 12-17)

PATIENT INFORMATION:

Last Name:_____ First Name:_____ Middle Initial:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Birthday:_____ Soc Sec#:_____ Phone#:_____

Gender: _____Male _____Female Other/Specifiy:_____

Race: ____White/Caucasian _____Black/African American _____Native Hawaiian/Other Pacific Islander ____Asian _____American Indian/Alaskan Native ____Refused

Ethnicity: _____ Hispanic or Latino _____Non-Hispanic or Latino _____Other _____Refused

Mother/Guardian Name: _____ Father/Guardian Name:_____

Pharmacy Name:_____ Location:_____

Emergency Contact: _____ Relationship:_____ Phone#:_____

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins Co Name: _____	**Ins Co Name:_____**
ID#_____	**ID#_____**
Subscriber Name:_____	**Subscriber Name:_____**
Birthdate:_____Relationship:_____	**Birthdate:_____Relationship:_____**
Employer:_____	**Employer:_____**

ADVANCED CONSENT TO TREAT MINORS AND RELEASE OF BENEFITS INFORMATION

I authorize my insurance benefits to be paid directly to Gilman Family Practice for services provided by them. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all copays, deductibles, and noncovered services. I give Gilman Family Practice permission to release my minor child's private health information required for treatment, referrals, payment, claims, and healthcare operations.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

I authorize and consent to routine and emergency medical treatment for _____ when deemed necessary by qualified medical personnel.
(Minor's Name)

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

CONTINUE ON REVERSE SIDE…..