HAWAI'I UTELEHEALTH

Registration Form

Preferred name (first and last) and pronouns (ex. she, he, they)
Legal name (if different from preferred)
Date of birth
Sex/gender (ex. female, intersex, male, nonbinary, transgender)
Home street address
Town
Island
Zip Code
Mailing address (if different from home address)
Email
Phone number(s)
Message may be left via email: ☐ No ☐ Yes Message may be left via text message: ☐ No ☐ Yes Message may be left via voicemail: ☐ No ☐ Yes
Guardian: Name, Email, Phone (if applicable)

Emergency contact: Name, Relationship, Phone
Primary care doctor: Name, Phone, Fax
Therapist: Name, Phone, Fax
Case manager/social worker: Name, Phone, Fax
Name of Primary Insurance Company
ID/Policy #
Your relationship to the subscriber (ex. Self, Parent, Spouse)
Subscriber's Full Name, date of birth, and employer
How did you hear about our services?
Name of person completing this referral (or "self")
Please state in a few words your primary reason for seeking services/goals of care
What type of clinician are you seeking?
☐ Primary Care
☐ Therapist/Counselor - mood, thoughts, behavior
☐ Therapist/Counselor - substance use
☐ Therapist/Counselor - relationship, family
☐ Therapist/Counselor - assessments: IQ, school testing, PASSR, etc.
☐ Psychiatrist/Medication Management (If you wish to see a psychiatrist and do not have a primary care provider or a therapist, you must establish care with them before seeing a HI Utele psychiatrist. You may request these providers through HI Utele at the same time as a psychiatrist)

☐ Medication Management - substance use
Prior Psychiatric Diagnoses (or “none”)
Current Psychiatric/psychotropic/mental health medications (or “none”)
Prior Psychiatric/psychotropic/mental health medications (or “none”)
Medical Diagnoses (or “none”)
Medications for physical health, herbs, vitamins, etc (or “none”)
If you would like to have an interpreter for your sessions, please state preferred language (or “n/a”)
Please check if you would like assistance with any of the following:
☐ access to a smartphone, tablet, or computer with webcam
☐ connecting to the internet
Days or times of the week you are unable to meet (or “none”)

CONSENT FOR TELEMEDICINE CONSULTATION
(Excluding Email)

REASON FOR / PURPOSE OF TELEMEDICINE CONSULTATION:

The University of Hawaii, through a grant from the Hawaii Department of Health, has arranged a videoconferencing link so that you may receive a telemedicine consultation from a health care provider. The health care provider is responsible for the recommendations that you receive.

DESCRIPTION OF TELEMEDICINE CONSULTATION:

Telemedicine is the delivery of health care services through the use of technology when the health care provider and the patient are not in the same location. Videoconferencing, e-health including patient portals, transmission of still images, remote monitoring of vital signs, continuing medical education, and nursing call centers are all considered part of telemedicine. Providers may include primary care practitioners, specialists, and/or sub-specialists.

The health care provider will communicate with you through videoconferencing. The health care provider will explain to you how to use the videoconferencing technology to communicate. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records;
- Medical images;
- Live two-way video and audio; and
- Output data from medical devices and sound and video files.

ANTICIPATED BENEFITS OF TELEMEDICINE CONSULTATION:

- Improved access to medical care by allowing a patient to remain in a different location from his/her health care provider during a consultation between the two.
- More efficient medical evaluation and management.

POTENTIAL RISKS OF TELEMEDICINE CONSULTATION:

As with any medical procedure, there are potential risks with the use of telemedicine. These risks include, but may not be limited to:

- The health care provider is not able to provide hands-on medical treatment nor provide or arrange for any emergency care that the patient may require during the telemedicine consultation.
- Security protocols could fail, causing a breach of privacy of the patient's personal medical information.
- Telemedicine equipment may be deficient or fail, causing delays in the patient's medical evaluation and treatment.
- The health care provider may not have access to the patient's complete medical records to allow for appropriate medical decision-making by the health care provider. This may result in the patient experiencing adverse drug interactions or allergic reactions or other medical judgment errors.
- In rare cases, information transmitted may not be sufficient (for example, poor resolution of images) to allow for appropriate medical decision-making by the health care provider.

CONFIDENTIALITY:

Your privacy and confidentiality will be protected. During the telemedicine consultation, you will be told who is in the room with the health care provider.

The laws that protect privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter that identifies you will be disclosed to researchers or other entities without your consent.

Electronic systems used will have network and software security protocols to protect the confidentiality of your health information. The electronic systems will have measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

COSTS OF PROCEDURE

In accordance with the policies and practices of the provider, the costs of the procedure may be billed to your insurance carrier. You may be responsible for any outstanding balance.

AVAILABILITY OF ALTERNATIVE TREATMENTS:

You do not have to agree to this telemedicine encounter. Instead, you may seek health care where you might have face- to-face or telephone contact with the health care provider.

QUESTIONS:

For any questions or concerns about the consultation, you may contact your health care provider.

***CONSENT FOR TELEMEDICINE CONSULTATION*:**

I, the Patient, certify that I have read and understand the information on this informed consent form and that all blanks were completed before my signature.

- The telemedicine consultation, benefits, and risks have been fully explained to me, and I understand this explanation.
- I understand that the telemedicine encounter may be a one-time occurrence and that treatment and follow-up will remain the responsibility of my provider.
- I understand that specific procedures may require additional informed consent from me.
- I understand that there are no guarantees with telemedicine.
- I have been given an opportunity to ask questions, and all such questions have been answered to my satisfaction

Signature Date

Printed Name

Hawaii HIPAA Authorization For Release Of Information

Use This Form To Allow The Release of Your Personal Health Information

Please keep a copy for your records

1. **Member Name** _____ **Phone** _____

   Address _____ **Date of Birth** _____

2. **List the personal health information you want to give out**
   - For example: "The claims information related to my hip surgery in January 2003," or "All my health information," or "All the records related to my heart problems"
   - Use a separate form for release of psychotherapy notes
   - You may also exclude some health information
     - For example: "all my health information except mental health records" or "all my medical records except x-ray films"

   _____

   _____

   ☐ Please check here if you authorize to give out information related to any of the following, should it be contained within your medical record:
   - HIV, AIDS, or AIDS-related complex diagnosis or treatment
   - alcohol or drug use, diagnosis, or treatment
   - mental health counseling, diagnosis, or treatment

3. **Name and address of the persons or organizations to give your personal health information**
   - For example: "My wife, Jane Doe" or "My grandson, John Doe"

   Name: _____ Address: _____

4. **Reason for the disclosure**
   - For example: "To answer questions about my claims" or "at the organization's request" or "for legal purposes"

   _____

5. **Right to take back ("revoke")**
   - I may revoke this authorization at any time by giving written notice. I understand my revocation will NOT affect any disclosures that occurred before my written revocation and there may be other legal restrictions on my ability to revoke this authorization. For example, I understand that the revocation will not apply if this authorization was a condition for obtaining insurance coverage, when the law provides my insurer with the right to contest my policy or a claim under my policy.
   - If I do not revoke it, this authorization will expire on the following date or event: _____
     For example: "12/31/2004"
     - If a date or event is not specified, this authorization will expire **one year** from the date of signature below
   - To revoke this authorization, I will write a letter including the following:
     - My name, address, and member number
     - The names of the persons or organizations I no longer wish to receive my personal health information
     - My signature
   - I will mail or fax the letter to: _____

6. **I authorize to give out the protected health information** described above to the persons or organizations I named on this form. This authorization is voluntary. I understand that the releasee will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law. I understand my protected health information may be re-disclosed by the recipient(s) without my permission and may no longer be protected by law.

Signature _____ Date _____