Phone Message Consent

From time to time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we like to leave messages when possible.

In order to protect your privacy, we have developed a policy on leaving messages.

We will not discuss any medical or financial information with anyone except the patient or legal guardian.
We will not leave any medical or financial information on an answering machine.
We will not leave any medical or financial information on a voice mail system or cell phone.
We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment.

UNLESS

We have your written permission to leave a message for you. Please read the information below and consider carefully whom you want to have access to your medical and/or financial information, such as test results. Please fill only ONE of the following sections below to make your preference known.

A. I DO CONSENT TO LEAVING DETAILED MESSAGES:
I, _____, give permission to Integrative Medicine Associates (William F. Corell, M.D.) and the staff my permission to leave phone messages regarding my medical care and/or financial status with the following:
(Please circle Medical and/or Financial or both)

Initial for each one you wish to have your messages

My home phone answering machine Phone #_____
My work phone voice mail Phone #_____
My cell phone Phone #_____
My spouse Phone #_____
Other (name) Phone #_____

Signature:_____ Date_____

B. I DO NOT CONSENT TO LEAVING DETAILED MESSAGES:
I, _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care and/or financial status and I do not authorize any messages on an answering machine, voice mail, cell phone or with others.

Signature:_____ Date_____

Email Consent

I, _____, give my permission to use clinical email between myself and Integrative Medicine and all of its associates.

I understand that email will only be exchanged between the clinic and myself. The email from me will include my full name and phone number. Email may not be received or responded to in a timely manner, and the clinician is not responsible for delays. Email may not be private and confidential. Email may be read by others, intercepted, or misaddressed. Email will be filed in my chart. Email will not be permanently stored on the computer system. Urgent issues need to be handled by phone or in person.

I also understand that appropriate uses of email include: appointment requests, refill requests, reminders, information requests, insurance or billing questions and referrals.

Signature:_____ Date_____

Email:_____

Patient Consent for Telemedicine Evaluation

(Provide original to physician and copy to patient.)

Patient

Identifying information [please print]:

Name: _____

Date of Birth: _____/_____/_____ [month/day/year]

Current Physical Address: _____

_____

Best Phone Number(s):_____

Email Address:_____

Physician

Identifying information:

William F. Corell MD and Integrative Medicine Associates (IMA)

3424 S. Grand Blvd., Spokane, WA 99203

509-838-5800

Telemedicine is a legal and accepted form of health care delivery in the state of Washington. It is the "practice of medicine using electronic communications, information technology or other means between a licensee in one location and a patient in another location." Because of my current health status, geographical location, or other mitigating circumstances, I am unable to participate in a face-to-face encounter with Dr. Corell and Integrative Medicine Associates, and hereby give my permission for IMA to review my medical history and records and perform an examination/evaluation using telemedicine technology. I understand that the intention of this encounter is to observe and evaluate my current health status, to educate me about my medical situation, and to provide appropriate treatment.

Signature of client and date:

Signature:_____Date_____