MDOI Medical Directors of Idaho PLLC | Partnered With VIRTARE HEALTH

CONSENT FORM

By signing this Consent Form, I understand that I am enrolling in Dr. Ryan Williams dba Medical Directors of Idaho PLLC, known as a Virtual Healthcare service provider. The service provider conducts chronic care management, principal care management, transitional care management, mental well-being services, and virtual/in-person healthcare services. This data is shared with the Centers for Medicare and Medicaid Services (CMS), enrolling member's health insurer and/or supplemental insurance company.

- ☐ **MEMBER CONSENT**: I give permission for the following services to be performed based on the care plan that is recommended for me. I understand that I may disenroll at any time.
- ☐ **RESPONSIBLE PARTY CONSENT**: I give permission for the following services to be performed based on the care plan that is recommended for the member I am enrolling. I understand that I may disenroll the member at any time. On behalf of _____

Yes / No	Service	Description
	Remote Patient Monitoring	Vitals/Biomarker monitoring and support
	Mental Well Being Services	Mental health screening and therapy
	Principle Care Management	Management of 1 chronic condition
	Chronic Care Management	Management of 2 or more chronic conditions
	Virtual/in Person Healthcare Services	Virtual or in-person healthcare visits by a medical provider in support of your existing healthcare team
	Remote Therapeutic Monitoring	Monitoring Medications/Environment

☐ **MEMBER CONSENT** ☐ **RESPONSIBLE PARTY CONSENT**

Member Name (PLEASE PRINT)	**Member Date of Birth**
Responsible Party Name	**Relationship to Member**
Signature	**Date**
Email	**Phone Number**

NOTE: Members and/or their family caregivers are advised to immediately contact 911 for any medical emergencies

Initials _____

Data Sharing and Release Agreement

I understand that Dr. Ryan Williams dba Medical Directors of Idaho PLLC complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and no medical information will ever be released without the member's consent. I understand that I may revoke this consent by written request, at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. I also understand that I have the right to restrict the disclosure of specific information in my medical record if I request such restriction in writing. I also understand that my request may be denied, if such information is required for Health Care Operations – which include, but are not limited to, provider review functions, claims processing and payment, and quality assessment. This consent is in response to federal laws that require consent for insurance processing.

Restrictions	

☐ **MEMBER CONSENT**: I authorize consent to the release of my past medical records.

☐ **RESPONSIBLE PARTY CONSENT**: I authorize the consent to the release of the enrolled member's past medical records.

Name	**Signature**	**Date**

Initials _____

Data Sharing and Release Agreement Continued

☐ **MEMBER CONSENT**: I authorize the service provider to use my de-identified information in a limited data set including the following identifiers: Dates, such as admission, discharge, service, and date of birth (DOB), City, state, and zip code (not street address), Age, Any other unique code or identifier that is not listed as a direct identifier. I understand a limited data set may be disclosed to an outside party without a patient's authorization only if the purpose of the disclosure is for research, public health, or health care operations purposes and the person or entity receiving the information signs a data use agreement (DUA) with the covered entity or its business associate.

☐ **RESPONSIBLE PARTY CONSENT:** I authorize the service provider to use the enrolled member's de-identified information in a limited data set including the following identifiers: Dates, such as admission, discharge, service, and date of birth (DOB), City, state, and zip code (not street address), Age, Any other unique code or identifier that is not listed as a direct identifier. I understand a limited data set may be disclosed to an outside party without a patient or responsible party's authorization only if the purpose of the disclosure is for research, public health, or health care operations purposes and the person or entity receiving the information signs a data use agreement (DUA) with the covered entity or its business associate.

Name	Signature	Date

Data Sharing and Release Agreement Continued

☐ **MEMBER CONSENT:** I allow the Service Provider to communicate with my Physicians, Emergency Contacts, and Individuals listed below to request any relevant medical information on my behalf. This includes sharing my data with my Physician, if medically necessary.

☐ **RESPONSIBLE PARTY CONSENT:** I allow the Service Provider to communicate with the enrolled member's Physicians, Emergency Contacts, and Individuals listed below to request any relevant medical information. This includes sharing data with the enrolled member's Physician, if medically necessary.

Name	Signature	Date

Contact	Relationship	Phone/Fax/Email

Initials _____