AUTHORIZATION AND RELEASE AGREEMENT
FOR DISASTER RELIEF MEDICAL ASSISTANCE

Name: _____

Cell Telephone: _____ Alternate Telephone: _____

Address: _____

Email: _____

1. The purpose of this form ("Agreement") is to obtain your consent to participate in an emergency medical consultation with a health care provider (including but not limited to a physician, physician assistant, specialist assistant, nurse practitioner, registered professional nurse, or licensed practical nurses).

2. You acknowledge and agree to the following:
    a. **Emergency.** You are seeking emergency medical advice (which may include a telemedicine consultation) because you are unable to gain access to a hospital or clinic because of reasons related to the COVID-19 pandemic. You understand that the health care provider desires to provide emergency medical assistance appropriate to his/her education, training, and experience. You agree that any responsibility to you will conclude upon the end of the visit (which may include termination of the video conference connection).
    b. **Not-for-Profit Organization.** JW Congregation Support, Inc., is a New York not-for-profit corporation organized, among other reasons, to provide humanitarian assistance in times of natural and man-made disasters. It is acting as a facilitator to connect those seeking emergency medical advice with a health care provider without charge. JW Congregation Support, Inc. is not a health care provider, does not provide medical services, and receives no compensation for the services it provides.
    c. **Unpaid Volunteer.** You understand that the health care provider with whom you will consult is a volunteer who is not paid for his/her services.
    d. **Risks.**
        i. You understand that it may be difficult or impossible for the health care provider to fully evaluate your condition due to the fact that you are not a current patient of the health care provider, the health care provider may not have access to your complete medical history, and you will not be in the same room as the health care provider.
        ii. You understand that there are potential risks to telemedicine technology including interruptions, unauthorized access, language barriers, and technical difficulties, including but not limited to, poor transmission of information or failure of equipment which could result in delay of medical evaluation or treatment.
        iii. You understand that due to the fact that you are not in the same room, it may not be possible for the health care provider to provide you with any medical assistance, and the extent of assistance that he/she may be able to provide is limited.
    e. Confidentiality. You understand that individuals other than a health care provider may be present during your consultation, including individuals needed to operate the video equipment.
    f. **Licenses and Related Regulations.** You understand that the health care provider may not be licensed in the jurisdiction where you live and is providing you with assistance as permitted by state law only because this is an emergency situation in

which you require immediate assistance and have been unable to obtain medical assistance from another source. You understand that, to the full extent allowed by state law, physician assistants may be providing medical services without the oversight of a supervising physician and nurse practitioners may be providing medical services without a written practice agreement or collaborative relationship with a physician.

3. **Consent.** By signing this Agreement below or by participating in a consultation described in this Agreement after reading this Agreement, you consent to participate in an emergency medical consultation with a health care provider and you accept and agree to all of the conditions and risks described in this Agreement.

4. **Release.** You agree to release (1) JW Congregation Support, Inc. and any organization cooperating with JW Congregation Support, Inc., to facilitate the services contemplated in this Agreement and (2) all health care providers from whom you may receive emergency medical assistance from liability, claims, and demands of whatever kind, either in law or in equity, which arise or may hereafter arise related to their efforts to assist you on an emergency basis to the full extent allowed by local laws or regulations. You acknowledge your intention to afford health care providers the full extent of protection afforded to them under any Good Samaritan laws that exist in the state, territory, or other location where you reside. You agree that, in the event that any provision of this Agreement shall be held to be invalid by any court of competent jurisdiction, the invalidity of such provision shall not otherwise affect the remainder of this Agreement, which shall continue to be held enforceable.

Signature: _____ Name: _____

Parent or Guardian Signature: _____ Name: _____

Date: _____