

TB Program Videophones

Release of Liability Form

Staff to mark (✓):

Yes	No	Information provided to Patient
		How to use the videophone
		How to care for videophone
		Who to call if questions

Videophone Serial #: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>
Date delivered: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>

TB Patient to read and mark (✓) for Yes

	I have been taught and provided information on the videophone.
	I understand and have demonstrated how to use the videophone.
	I understand this videophone is for my use only while receiving treatment for tuberculosis. I will not loan or give this videophone to anyone else.
	I agree not to bring any financial or personal liability claim against the OR State DHS Tuberculosis Program, its contractors or local agencies, or any official or employee connected with the Tuberculosis Program, for any damages, expenses, or personal harm arising from the use of this videophone.
	I agree to return this videophone with all attached phone cords/cables in clean and working condition within four business days of the end of therapy.
	I understand this videophone is the property of the OR State DHS Tuberculosis Program. If I do not return it, or return it as damaged, collection proceedings could be filed. I could be asked to pay up to \$200 for the cost of the unreturned or damaged videophone.
	I will call the TB staff of (name LHD) _____ at (phone number) _____ if I have any concerns or questions about the use of this videophone.
	I have read and fully understand this form and will be provided a copy.
Patient (Parent/Guardian) Signature/Date:	Staff Signature/Date: