Ashley PEDIATRICS
Day and Night Clinic

Industrial Health Works
OCCUPATIONAL & FAMILY MEDICINE CLINIC

QUALITY URGENT CARE CENTER
801 E. Nolana, Ste. 9, McAllen, TX. 78504 • 956-270-4719
WE HAVE YOUR HEALTH UNDER CONTROL

Informed Consent for Telemedicine

Date Consent Discussed:	Preferred Patient Phone #:
Patient Name:	
Patient's DOB:	
Witness Name:	
Clinic Name & Location:	

1. I voluntarily request Ashley Pediatrics/Industrial Health Works/Quality Urgent Care Center (circle one) providers to participate in my medical care through a Telemedicine exam. I understand that, at my provider's discretion, I may need to be seen in person.
2. I understand that the Telemedicine exam may be done on the telephone, allowing the provider to hear my voice, or through an interactive two-way video that allows the provider to hear my voice and see my image. The provider, however, will not have the opportunity to perform an in-person physical examination and must rely on information provided by me. For this reason, my Telemedicine exam may not be equal to a face-to-face visit and the providers' recommendations and/or decisions may be based on factors not within their control, such as incomplete or inaccurate information provided by me or distortions of images that may result from electronic transmissions.
3. I understand that there are potential risks to using Telemedicine technology, including service interruptions, interception, and technical difficulties. I understand, and it has been explained to me, that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time (such as an in-person visit).
4. I understand that the disclosure of my medical information to the provider's clinic will be by electronic transmission and may be compromised by failures of security safeguards or illegal and improper tampering despite the best efforts of the clinic to protect the confidentiality of this information.
5. This consent will remain valid for 12 months from the date of my first telehealth visit with the practice listed at the top of this consent. I understand that I may withhold or withdraw consent for telemedicine consultations at any time without affecting my right to future care or treatment.

Patient Name:_____

I certify by my signature below that I have fully read this form to the patient. The patient has verbalized understanding and authorized this clinic and its providers to proceed with a Telemedicine exam.

Witness:_____ Date:_____