Pathways
Developmental Pediatrics
Personalized care for individual minds

Telemedicine Consent Form

Today's Date:_____

Child's Name:_____ _____ Child's Date of Birth: _____
First Last

1. I understand that my health care provider, Dr. Evelyn Frazier at Pathways Developmental Pediatrics wishes me/my child to engage in a Telemedicine visit.
2. I hereby authorize and voluntarily consent to Pathways Developmental Pediatrics and Dr. Evelyn Frazier to provide me/my child with basic treatments and medical and diagnostic procedures.
3. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction,and may receive copies of this information for a reasonable fee.
6. I understand 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 this time. My provider has explained the alternatives to my satisfaction.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care. But that no results can be guaranteed or assured.

By signing this consent, I authorize my health professional to release any and all relevant information to my insurance company or any other agent which may be responsible for paying my medical bills.

I have read this document carefully, and hereby consent to participate in the Telemedicine Consultation under the terms described above.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**

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