West Bend Family Medicine
Electronic Transmission Disclosure and Acceptance

1. Member(s) understand(s) that the various forms of electronic transmission of information carry with them the unlikely yet possible risk of exposure and potential loss of that information for a variety of reasons.

2. By signing below, Member(s) is/are indicating a desire to do business with West Bend Family Medicine providers via any or all these electronic methods of communication, as indicated below (please initial next to those methods desired, you are not required to choose any of these modalities if you do not want access to these features):

   _____Cell phone **texting** via **secure** app (including attached pictures when applicable).

   _____Patient portal **emails** via **eClinical Works** electronic medical records.

   _____Video conferencing also known as **Telemedicine** via **eClinical Works**.

   Please use Email Address _____
   Please use Cellphone Number _____

3. By signing this document, Member(s) agree(s) to accept the risks inherent in the use of any of the above indicated communication methods for the purpose of diagnosis, treatment, or any other healthcare or business-related reason. Member(s) further agree(s) to indemnify and holdharmless West Bend Family Medicine and its affiliated clinics or providers in the possible but unlikely event of a breach of confidential or protected information.

_____ _____
Member Signature Date

_____ _____
Parent or Legal Guardian Signature Date