GULF COAST SLEEP SPECIALIST

DR. STEVEN E. TODD DMD

THE LANDMARK BUILDING

316 S. McKenzie St. Ste 171 Foley, AL 36535

Informed Consent for Telemedicine Services

Patient Name: _____

Date of Birth: _____

Location of Patient (address): _____

_____

Today's Date: _____

Provider Name:

Provider Location:

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my