Anesthesia
& Sleep Medicine
Services of Florida

Neurologic Health & Restorative Sleep

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Diplomate of the American Board of Anesthesiology
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CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Telemedicine involves the use of electronic communications to enable health care providers evaluate, diagnosis, manager and treatment of a number of health care problems. Providers may include primary care practitioners, specialists, and/or subspecialists.

I wish to participate as a patient in a telemedicine consultation at Anesthesia and Sleep Medicine Services of Florida.

By signing this form, I Understand the following:

1. I understand that my specialist will be at a different location from me. My provider, Dr. Phillip Nye, Diplomate of the American Board of Anesthesiologists and is fellowship trained in treating sleep disorders, will be communicating by interactive video conferencing.
2. I reside in Florida, where my sleep medicine doctor is licensed to practice medicine.
3. I understand that a sleep specialist and their staff will see my detailed medical history.
4. I understand that laws protecting privacy and the confidentiality of medical information also apply to telehealth, and no identifying information from my telemedicine consult will be disclosed to researchers or others without my consent.

5. I have the right to withdraw my consent to use of telemedicine during the course of my care at any time, without affecting my right to future care or treatment.
6. I understand the video portion of my telemedicine consult will involve electronic communication of my personal medical information.
7. A record of the consultation will be kept in my electronic medical record.
8. I understand, and do not hold Anesthesia and Sleep medicine Services of Florida responsible, there are potential risks with this technology including: interruptions, unauthorized access and technical difficulties.
9. I am aware that I may expect benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my health care.

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Patient Signature Patient Printed Name