TIDEWATER NEUROLOGISTS, INC. and
SLEEP DISORDER SPECIALISTS
SLEEP DISORDER CENTERS

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Board Certified Sleep Medicine, ABPN
Diplomate of the American Board of Sleep Medicine
Fellow, American Academy of Sleep Medicine

Eric Goldberg, M.D.
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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 Tidewater Neurologists and Sleep Disorder Specialists. By signing this form, I _____ understand the following:

1. The consulting health care provider or specialist will be at a different location from me. My health care provider, Dr. Hemang Shah / Dr. Eric Goldberg, Diplomate of the American Board of Neurology and Psychiatry and such assistant as may be selected, will communicate by interactive video conferencing.
2. I reside in the State of Virginia and am currently in Virginia (during this consultation), where my health care professional is licensed.
3. The presenting health care provider or professional health care staff will see details of my medical history.
4. I understand that the laws that protect privacy and the 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.
5. I understand that I have the right to 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.
6. I understand that video part of telemedicine may involve electronic communication of my personal medical information.
7. A record of the consultation will be kept in my medical record.
8. I understand, and hold harmless Tidewater Neurologist and Sleep Disorder Specialists of Virginia, there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
9. 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.

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

_____ _____

Patient Signature Patient Printed Name