SCENT
ALLERGY & SLEEP MEDICINE

Informed Consent for Telemedicine Services

Introduction:

Telemedicine involves the use of electronic devices to enable two-way communication between patients and their doctors/providers at different locations for the purpose of diagnosis, follow-up and/or education. Transmitted information may include any of the following:

- Patient medical records
- Live two-way audio and video
- Patient materials such as prescriptions and lab requisitions may be sent to the patient via email upon request.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected benefits:

- Improve access to medical care by enabling a patient to remain in his/her home or workplace for simple issues such as medication refills or discussing diagnostic testing results.
- More efficient medical evaluation and management.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician/provider and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failure of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

By signing this form, I understand the following:

1. 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 researches or other entities without my consent.
2. 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.
3. 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.
4. I understand that I may choose to make an in-person appointment at any time.

5. I understand that the doctor may recommend I schedule an in-person appointment to address issues that cannot be adequately addressed through telemedicine.
6. I understand that telemedicine involves encrypted electronic communication of my personal medical information.
7. I understand that I may expect the anticipated benefits form the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I consent that my insurance carrier can be billed for these services. I understand that I will be responsible for any copayments, co-insurance or deductibles that may apply.

Patient Consent To The Use of Telemedicine

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

I hereby authorize South Carolina ENT, Allergy & Sleep Medicine to use telemedicine in the course of my diagnosis and treatment.

Name of Patient: _____

Signature of Patient: _____

Date: _____