

# Community Psychiatry

## Telepsychiatry Consent Form Community Psychiatry

I hereby authorize \_\_\_\_\_ / Community Psychiatry to use telepsychiatry in the course of my diagnosis and treatment. I understand that telepsychiatry involves the communication of my medical information, both orally and/or visually, to physicians and other health care practitioners located in other parts of the state or outside of the state.

I understand I have all the following rights with respect to telepsychiatry:

Patient Choice of Care. I have the right to withhold or withdraw my consent to telepsychiatry at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

Access to Information. I have the right to inspect all medical information that includes the telepsychiatry visit. I may obtain copies of this medical record information for a reasonable fee.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telepsychiatry. My video telepsychiatry visit will not be recorded and all identifying information in the interaction will be kept secure in the same manner as any other private medical information.

Potential Risks. I understand that there are risks from telepsychiatry. These risks include the possibility (despite our best efforts to prevent this) that the transmission of medical information could be disrupted or distorted by technical failures in transmission. I also understand that the electronic transmission of medical information could be interrupted or even accessed illegally by unauthorized persons.

In addition, I understand that telemedical examinations or care may not be as complete as a face-to-face examination or care. I understand that telepsychiatry does not decrease or minimize the risks that might be present in a medical illness or condition.

Finally, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.

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## Telepsychiatry Consent Form (Cont'd) Community Psychiatry

Consequences. I understand that by consenting to telepsychiatry my physician will communicate medical information concerning me to physicians and other health care practitioners located in other parts of the state or outside the state, such as my Personal Care Physician and/or therapist.

Benefits. I understand that I can expect benefits from telepsychiatry, but that no results can be guaranteed or assured. Telepsychiatry provides me with access to medical care that otherwise would not have been available in my community.

I have read and understand the information provided above, I have discussed it with my physician or my physician's staff, and all my questions have been answered to my satisfaction.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient / parent / conservator / guardian (circle one)

\_\_\_\_\_  
Print Name

- parent or guardian of minor patient  
 guardian or conservator of an incompetent patient

Name and Address of Patient:  
\_\_\_\_\_  
\_\_\_\_\_