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TELEPSYCHIATRY INFORMED CONSENT

Patient Name: _____ Date of Birth:_____
Patient's City and State of Residence: _____

Introduction
Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing.
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:
• Improved access to psychiatric care by enabling a patient to remain in his/her home or office.
• More efficient psychiatric evaluation and management.
• Obtaining expertise of a distant specialist.

Possible Risks:
As with any medical procedure, there are potential risks associated with the use of telepsychiatry. 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, mental health provider and consultant(s);
• Delays in medical evaluation and treatment could occur due to deficiencies or failures 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 telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry 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 telepsychiatry interaction, and may receive copies of this information for a reasonable fee.
4. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my mental health provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care.

I hereby authorize Dr. Igor Epstein, psychiatrist to use telepsychiatry in the course of my diagnosis and treatment.

I understand that I may receive a copy of this release.

_____ _____
Patient's Signature Date

_____ _____
Witness (if applicable) Date