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Psychiatry
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Telepsychiatry Informed Consent

Introduction: Telepsychiatry is an extension of patient care that allows patients to access psychiatric care using audio-video interface videoconferencing. Electronic videoconferencing systems used will incorporate network and software security protocols including but not limited to encrypted data transmission of video conference, password protected screen savers and privacy protected virtual waiting rooms to protect the confidentiality of patient identification and imaging data. This will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

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, internet quality) to allow for appropriate medical decision making by the physician. If teleconferencing transmission is temporarily insufficient, Dr. Schwartz may ask that the session be completed over the phone until transmission can be improved;
- 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 a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time.
3. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I agree to take full responsibility for the security of any communications or treatment on my own device and in my own physical location. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Dr. Schwartz, and all of my questions have been answered to my satisfaction. I have discussed confidentiality and limits of confidentiality in electronic communication, I have agreed upon an emergency plan with Dr. Schwartz, I understand that conditions may arise under which Dr. Schwartz may terminate telepsychiatric services and in-person care will be required. I hereby give my informed consent for the use of telepsychiatry in my medical care.

I hereby authorize Dr. Schwartz to use telepsychiatry in the course of my diagnosis and treatment.

Please Print Patient's Name: _____ Date:_____

Signature of Patient (or person authorized to sign for patient): _____

If authorized signer, print name and relationship to patient:_____