sPatient Information and Consent Form for Telepsychiatry

This consent form for telepsychiatry is entered into on ________ (date) by _______ (patient) and ______ (Uptown Psych Treating Provider)

Introduction

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist or nurse (provider) and the patient are not in the same location. The interactive electronic systems used in telepsychiatry incorporate network and software security protocols (encryption) to protect the confidentiality of patient information and audio and visual data.

Potential Benefits of Telepsychiatry

- Increased accessibility to psychiatric care.
- Patient convenience.

Potential Risks with Telepsychiatry

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

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by your Uptown Psych Treating Provider
- Your Uptown Psych Treating Provider may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or range for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, (although extremely unlikely) causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face-to-face visit but not in telepsychiatry session may result in errors in medical judgment.

Alternatives to the use of Telepsychiatry

- Traditional face to face sessions in your Uptown Psych Treating Provider's office.

Confidentiality Standards required for Telepsychiatry

- During a tele mental health session, both locations shall be considered a patient examination room regardless of a room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
- Rooms shall be designated private for the duration of the session with the Doctor and no unauthorized access shall be permitted.
- Both sites shall take every precaution to ensure the privacy of the consult and the confidentiality of the patient. All persons in the exam room at both sites shall be

identifiable to all participants prior to the consultation and the patient's permission shall be obtained for any visitors or clinicians to be present during the session.
- HIPAA confidentiality requirements apply the same for telepsychiatry as for face-to-face consultations.

My Rights

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2. I understand that the video conferencing technology used by my Uptown Psych Treating Provider is encrypted to prevent unauthorized access to my private medical information.
3. I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time. Understand that my withdrawal of consent will not affect any future care or treatment.
4. I understand that my Uptown Psych Treating Provider has the right to withhold or withdraw their consent for the use of telepsychiatry during my care at any time.
5. I understand that all rules and regulations which apply to the practice of medicine in the state of Illinois also apply to telepsychiatry.
6. I understand that my Uptown Psych Treating Provider will not record any of our telepsychiatry sessions without my prior written consent.

My Responsibilities

1. I will not record any telepsychiatry sessions without prior written consent from my Uptown Psych Treating Provider.
2. I will inform my Uptown Psych Treating Provider if any other person can hear or see any part of our session before the session begins. My Uptown Psych Treating Provider will inform me if any other person can hear or see any part of our session before the session begins.
3. I understand that third parties may be required to join in the meeting with my doctor and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for video conferencing, I may forfeit my option to use telepsychiatry.
4. I understand that I, not my Uptown Psych Treating Provider, am responsible for the configuration of equipment on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third-party (Secure Telehealth) for technical support to determine my computer's readiness for telemedicine prior to beginning tele psych sessions with my doctor.
5. I understand that I must be a resident of the state of Illinois to be eligible for telepsychiatry services from my Uptown Psych Treating Provider

Patient Consent to the use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry and have discussed it with my Uptown Psych Treating Provider and all of my questions have been answered to my satisfaction.

Signature of Patient (or person authorized to sign for patient):
Full name ______________________ Signature____________________ Date: ___________

I authorized signer, relationship to patient: _____________________________

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Uptown Psych Treating Provider