

Patient Information and Consent Form for Telepsychiatry

Introduction

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location.

The interactive electronic systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

My Rights

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

I understand that the telepsychiatry platform used by CEH is encrypted to prevent the unauthorized access to my private medical information.

I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

I understand that the CEH provider has the right to withhold or withdraw his consent for the use of telepsychiatry during the course of my care at any time.

I understand that the all rules and regulations which apply to the practice of medicine in the state of North Carolina also apply to telepsychiatry.

My Responsibilities

I will not record any telepsychiatry sessions without written consent from a CEH provider. I understand that all CEH providers will not record any of our telepsychiatry sessions without my written consent.

I will inform a CEH provider if any other person can hear or see any part of our session before the session begins.

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I understand that I, not the CEH provider, am responsible for the configuration of any electronic equipment used 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 must be a resident of the state of North Carolina to be eligible for telepsychiatry services from CEH.

I understand that my initial evaluation will not be done by telepsychiatry except in special circumstances under which I will required to verify my identity to his satisfaction before the evaluation.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with a CEH provider 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 and authorize Center for Emotional Heath to use telemedicine in the course of my diagnosis and treatment.

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

If authorized signer, relationship to Patient: _____

Date: _____