TELEPSYCHIATRY CONSENT

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telepsychiatry is the delivery of psychiatric services using interactive video conferencing that enables a psychiatrist or his associates at a distant location to provide treatment to me. I understand that this consultation will not be the same as direct patient/psychiatrist visit. Telepsychiatry will allow me to receive medical care without the need to visit the office and travel long distance.

* Client health records
* Live two-way audio and video
* Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Expected Benefits:**

* Increased accessibility to psychiatric care
* More efficient client evaluation and management.
* Patient convenience

**Possible Risks:**

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 decision making by the providers 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 health information;
* In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors;

**By signing this form, I understand the following:**

* I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
* I understand that Zoom/Google Meets technology used by Dr. Liu is encrypted to prevent the unauthorized access to my private medical information.
* 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.
* I understand that all rules and regulations which apply to the practice of medicine in the state of Maryland also apply to telepsychiatry
* I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
* I understand that telepsychiatry involves electronic communication of my personal health information
* 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 Use Telehealth**

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my physician, and all of my questions have been answered to my satisfaction. I understand that I can opt out at anytime with written notice. I hereby give my informed consent for the use of telepsychiatry in my care and authorize Dr. Liu or Dr. Gavett-Liu to use telepsychiatry in the course of my diagnosis and treatment. If for any reason(s) telepsychiatry will not work for my treatment, then I will seek another provider for ongoing evaluations and treatments in person.

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| Signature of Patient/Parent/Personal Representative  | Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Printed Name of Patient/Parent/Personal Representative | Relationship to Patient |