Informed Consent for Telepsychiatry

Introduction

Telepsychiatry involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. Methodist Services utilizes telepsychiatry to supplement the delivery of psychiatric office visits for the purpose of efficient access to quality mental health care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video

Electronic systems provided by a third party vendor , Genoa Healthcare Telepsychiatry and/or Doxy.Me, 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 mental health care by enabling a patient to remain in his/her local office while consulting with healthcare practitioners at distant/other sites.
- More efficient evaluation and medication management. (Reduced wait times)
- Flexibility in delivery of services for situations that would impose a limitation on office appointments i.e.COVID-19 national emergency
- 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 and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Though every attempt is made to safely encrypt delivery of telepsychiatry service, 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 and recorded in the course of a telepsychiatry interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical 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.

5. I understand that tele psychiatry may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. 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 physician 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 Methodist Services Community Counseling Services to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): ____ *Date:*___________

*If authorized signer, relationship to patient:*____

Witness: ____ *Date:*____________

I have been offered a copy of this consent form (patient's initials) _______