Family Psychiatry of Georgia, LLC.
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Tele-psychiatry Informed Consent

Patient Name/Guardian: _____ Date of Birth:_____
Location/Address: _____

Introduction:

Tele-psychiatry/telemedicine allows patients to access psychiatric care using audio-video interface such as videoconferencing.
Electronic systems used 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.

Potential Benefits:

- Improved access to psychiatric care by enabling a patient to remain in his/her home or office.
- More efficient psychiatric evaluation and management.
- Obtaining expertise of a distant specialist.

Potential 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;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- A tele-psychiatry session will not be exactly the same, and may not be as complete as a face-to-face service.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors.

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 tele-psychiatry, 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 in the course of a tele-psychiatry interaction, and may receive copies of this information for a reasonable fee.
4. 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.

Please initial after reading this page: _____

Patient's Responsibilities

1. I will not record any Tele-psychiatry sessions and maintain privacy during the session. I understand that my provider will not record any of our Tele-psychiatry sessions without my consent.
2. I will not allow any other individual to listen to, review or record my Tele-psychiatry sessions.
3. I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
4. I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for Tele-psychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
5. I understand that my initial evaluation will not be done by Tele-psychiatry except in special circumstances under which I will be required to verify my identity.

Patient Consent to the use of Tele-psychiatry services:

I have read and understand the information provided above regarding tele-psychiatry, have discussed it with my psychiatrist or such assistants as may be designated, and all of my questions have been answered. I hereby give my informed consent for the use of tele-psychiatry in my medical care.

I hereby authorize Dr. Rajouria-Malla and Family Psychiatry of Georgia to use tele-psychiatry in my medical care.

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

*Date & place:*_____

*Relationship to patient:*_____

*Witness:*_____ *Date:*_____

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