BROWNHealth UNIVERSITY

Informed Consent for Telemedicine

Before we start our psychiatric treatment using telemedicine, I need to inform you and you need to understand that:

- You are consenting to the discussion of your confidential and protected health information (PHI) and to treatment by interactive audio, video, or data communications, so called "telemedicine," which includes the exchange of information, both orally and visually, as if we were having a discussion at the hospital or other treatment site.
- You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you may otherwise be entitled.
- The information disclosed by you during the course of your psychiatric treatment is generally confidential under law, unless such disclosures are mandated or permitted under law such as for, among other reasons, reporting child, elder, and dependent adult abuse; or if there are expressed threats of violence towards an ascertainable victim.
- There are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts, that: the transmission of your medical information could be disrupted or distorted by technical failures, or interrupted or intercepted by unauthorized persons during transmission and/or electronic storage of your medical information.
- If you are participating in group therapy, your participation may be either remote, from outside of our treatment setting, or on-site. Similarly, other group participants may be participating remotely or on-site. In order to protect the privacy of these groups, we ask you agree to certain restrictions. If you participate remotely, you agree to do so from a private area of your home. You also agree to ensure that only those family members identified as participants may see or hear these groups. Finally, you will not discuss, record, or share private information from the group, including the identity of participants or the content of the discussion, with anyone other than the group participants and treatment team.
- Telemedicine based services and care may not be as complete as face-to-face services, and you may be better served by another form of psychiatric treatment services (e.g. face-to-face services) which can be discussed if indicated.
- You understand that there are potential risks and benefits associated with any form of psychiatric treatment, and that despite our best efforts, your condition may not improve, and in some cases may even get worse.
- Your health insurance plan will be billed for telemedicine services. If required, you will be responsible for any co-payments or deductibles.

Does patient age 16 or older (or parent/guardian/conservator if patient under 16) verbally agree to participate in this psychiatric treatment session via telemedicine? (Please scan document into the media tab of the EMR)
YES ☐ NO ☐

Consent was obtained from patient (or parent/guardian/conservator) telephonically YES ☐ NO ☐

If yes, person who obtained consent via telephone: _____ Date & Time: _____

Patient Signature (if over 16): _____ Date & Time: _____

Parent/Guardian/Conservator Signature: _____ Date & Time: _____

Parent/Guardian/Conservator Printed Name: _____ Date & Time: _____

Relationship of Parent/Guardian/Conservator:_____ Date & Time: _____