TELEPSYCHIATRY CONSENT FORM

Telepsychiatry provides psychiatric services using interactive video and visual conferencing tools, in which the psychiatrist/Provider and the patient are not at the same location.

Telepsychiatry will allow the patient to receive medical care without the need to visit the office and travel long distance.

Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment.
Alternative to telepsychiatry include traditional face to face sessions.

MY RIGHTS:

1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2) I understand that the telepsychiatry platform used by VITAG HEALTH is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.
3) I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time.
4) I understand that my withdrawal of consent will not affect any future care or treatment. 5) I understand that VITAG HEALTH provider has the right withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.
5) I understand that all rules and regulations which apply to the practice of medicine in the State of New Jersey and New York also apply to telepsychiatry.

MY RESPONSIBILITIES

I will not record any telepsychiatry sessions without written consent from VITAG HEALTH. I understand that all VITAG HEALTH providers will not record any of our telepsychiatry sessions without my written consent. I will inform VITAG HEALTH if any other person can hear or see any part of our session before the session begins. VITAG HEALTH provider will inform me if any other person can hear or see any part of our session before the session begins. I understand that I, the patient Not the provider, is 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 all providers working for VITAG HEALTH are licensed in the state of New Jersey and New York

I have read and understand the information provided above regarding telepsychiatry, have discussed it with VITAG HEALTH 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 VITAG HEALTH 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: _____

Patient_____ Date_____