INFORMED CONSENT FOR TELE PSYCHIATRY SERVICE

PHYSICIAN/ CLINIC: MID-FLORIDA PSYCHIATRY CENTER. (DR. VANGALA/ PAs and PMHNP's WORKIING FOR DR. VANGALA)

Introduction: Telepsychiatry involves the use of electronic communications to enable health care providers/ psychiatrists to interact with patients via video and or audio means to provide care to the patients who are at a remote location. It may be used for diagnosis, therapy, follow-up and/or education. 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.

Expected Benefits:

a) Improved access to medical care by enabling a patient to remain in his/her home or PCP's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites (for example: clinic).
b) More efficient medical evaluation and management.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of tele psychiatry. These risks include, but may not be limited to:
i) 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.
ii) Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
iii) In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
iv) In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment 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 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 tele psychiatric interaction and may receive copies of this information for a reasonable fee, if requested.
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.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I understand that the video and or audio is not recorded by the clinic or by me without prior authorization or separate consent.

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 mental health care.

To be signed by Patient (or person authorized to sign for patient)