Connecticut Institute of Behavioral Health Inc.
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TELEPSYCHIATRY INFORMED CONSENT

Patient Name:_____ Date Of Birth:_____

Telepsychiatry is a form of telemedicine that allows clients to access psychiatric care using electronic communications to enable health care providers at different locations to share individual client medical information for the purpose of improving client care. The information may be used to diagnosis & treat, psychotherapy, follow- up and / or client education.

Purpose
The purpose of this form is to obtain your consent to participate in our telepsychiatry services.

Benefits of Telepsychiatry

- Improved access to psychiatric care by enabling a client to remain at his / her own home or office.
- More efficient psychiatric evaluation and management

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 mental health professions.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

Medical Information & Records
All existing laws regarding your access to medical information and copies of your medical records apply to telepsychiatry services. Please note that telecommunications are not recorded or stored.

Confidentially
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data to ensure its integrity against or unintentional corruption.

By signing below, you are acknowledging that you agree to participate in telepsychiatry services.

Signature of Client or Authorized Legal Representative:_____ Date: _____

Printed name of Client or Authorized Legal Representative: _____