

**Puget Sound Psychiatric Center**

**10634 E Riverside Drive, Suite 130**

**Bothell, WA 98011**

**Phone: 425-806-5021**

**Fax: 425-486-3949**

**Informed Consent to Telepsychiatry Services**

**Patient Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Of Birth:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Introduction**: **Puget Sound Psychiatric Center**, during the course of providing outpatient treatment services, may offer the option for patients to participate in telepsychiatry, a form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing. Specifically, patients may receive telepsychiatry services for: psychiatric evaluation and treatment, initial intake and assessment, and counseling. 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:** The expected benefits of the telepsychiatry include, but may not be limited to:

• Improved access to psychiatric care;  
• More efficient psychiatric evaluation and management;  
• Obtaining expertise of a distant specialist.

**Possible Risks:** As with any medical procedure, there are potential risks associated with the use of telepsychiatry. In rare instances, these risks could include, but may not be limited to:  
  
• 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;  
• Security protocols could fail, causing a breach of privacy of personal medical information; and  
• A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors.  
  
**Representations:** By signing this form, I understand the following:  
  
1. The laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry.   
2. 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 have the right to inspect all information obtained in the course of a telepsychiatry interaction, and may receive copies of this information for a reasonable fee.  
4. It is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.  
5. 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.   
6. It is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.  
7. I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.  
8. I shall hold the **Puget Sound Psychiatric Center** harmless for information lost due to any technical failures.

**PATIENT CONSENT TO THE USE OF TELEPSYCHIATRY**

I have read and understand the information provided above regarding telepsychiatry, have been given the opportunity to discuss it with my psychiatrist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry as and if needed during the course of my medical care.  
  
I hereby authorize **Puget Sound Psychiatric Center** and its medical providers to use telepsychiatry in the course of my diagnosis and treatment as needed.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_