Consent to Telemedicine

I hereby consent to the use of telemedicine by my Community Psychiatry provider. I understand that telemedicine involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than me. I understand I have all of the following rights with respect to telemedicine:

Patient Choice. I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future treatment.

Access to Information. I have the right to inspect and receive copies of all medical information transmitted during a telemedicine consultation. I understand that my telemedicine provider will communicate my relevant health information to physicians and other health care practitioners involved in my treatment who are located in different offices or clinics in the state, such as my primary care physician or therapist.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine, that I will not be recorded, and that no information from my telemedicine consultations which identifies me will be disclosed to third parties without my consent.

Potential Risks. I understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted and stored pursuant to the telemedicine consultation. I understand that telemedicine is an alternative to in-person treatment and my doctor may recommend I discontinue telemedicine and receive in-person treatment in certain circumstances. I understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are

not listed here.

Benefits. I understand that I can expect benefits from telemedicine, but that no particular results can be guaranteed. I understand that telemedicine may provide me with access to psychiatry services that otherwise would not have been available to me.

Residing in California. I understand that I must be physically residing in California during my telemedicine appointments and agree to notify front office staff or my provider if I will be out of the state during my scheduled telemedicine appointment so that the appointment can be rescheduled.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature ______________________ Date __________

Patient Name ______________________

If you are signing this Consent to Telemedicine as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Health Care Surrogate
- ☐ Power of Attorney for Health Care
- ☐ Executor/ Administrator

Signature ______________________ Date __________

Name ______________________