Hamilton Behavioral Telepsych Disclosure

Patient Information and Consent Form for Telepsychiatry

Introduction Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location.

The interactive electronic systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

My Rights I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry. I understand that the telepsychiatry platform used by Hamilton Behavioral (HB) is encrypted to prevent the unauthorized access to my private medical information. I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. I understand that the HB provider has the right to withhold or withdraw his consent for the use of telepsychiatry during the course of my care at any time. I understand that the all rules and regulations which apply to the practice of medicine in the state of New Jersey also apply to telepsychiatry.

My Responsibilities I will not record any telepsychiatry sessions without written consent from a HB provider. I understand that all HB providers will not record any of our telepsychiatry sessions without my written consent. I will inform a HB provider if any other person can hear or see any part of our session before the session begins. HB 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, not the HB provider, am 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 HB are licensed in the state of New Jersey.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with a HB 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 and Hamilton Behavioral 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: ____

Date:____