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Informed Consent for Telepsychology Services

Patient Name: _____

Date of Birth: _____

Parent/Guardian if patient is child _____

Introduction:

Telepsychology involves the use of electronic communications to enable healthcare providers to deliver psychological services to the patient in other locations besides the psychologist's office. The patient can remain in the home, at their place of business, or another location not in the same physical location as the psychologist. It makes use of audio and/or video conversations and discussions though the use of computers (lap top, desk top, smart phones) by patients and psychologists.

In that way, information can be remotely gathered, counseling delivered, and some limited psychological testing performed. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the information and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to psychological care by enabling the patient to remain in their home or elsewhere while the psychologist is in his/her office or elsewhere. This reduces travel time to the patient.
- It also can provide a more relaxed setting for the patient to interact with the psychologist.

Possible Risks:

As with any psychological procedure, there are potential risks associated with use of Telepsychology. These risk include but may be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor realization of images) to allow for appropriate decision-making by the psychologist and patient.
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal psychological information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of psychological information will apply to Telepsychology, and the new information obtained in the use of Telepsychology which notifies me will be disclosed to other persons without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telepsychology in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of psychological care may be available to me, and that I may choose one or more of these at any time. My psychologist can refer me to other professional persons if I so request.
4. I understand that it is my duty to inform a psychologist of electronic interactions regarding my care that I may have with other healthcare providers.
5. I understand that I may expect the anticipated benefits from the use of Telepsychology in my care but that no results can be guaranteed or assured.

Patient Consent to the Use of Telepsychology

I have read and understand the information provided above regarding Telepsychology, have discussed it with my psychologist as needed, and have had all my questions answered to my satisfaction. I hereby give my informed consent for the use of Telepsychology in my psychological care.

I hereby authorize John Stoudenmire PhD to use Telepsychology in the course of my diagnosis and treatment.

Signature of patient (or person
Authorized to sign for patient): _____ Date: _____
(Signature)

If authorized signer,
Relationship to patient: _____ Date: _____

Name of witness: _____ Date: _____
(Printed Name)

Witness signature: _____ Date: _____
(Signature)