**Telepsychiatry Consent Form**

Telepsychiatry provides mental health services using interactive video conferencing tools, such as Zoom, in which the therapist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical/mental health care without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in clinical judgment. Alternative to telepsychiatry include traditional face to face sessions.

**Your Rights:**

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;
2. I understand that Zoom platform is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the Zoom security features at the following site. <https://zoom.us/docs/doc/Zoom-Security-White-Paper.pdf>
3. I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.
4. I understand that Dr. Lisa Karabelnik has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time;
5. I understand that all rules and regulations which apply to the practice of medicine in the State of Connecticut also apply to telepsychiatry.

**Your Responsibilities:**

1. I will not record any telepsychiatry sessions without the prior written consent of Pinnacle Behavioral Heath and I understand that Dr. Lisa Karabelnik will not record telepsychiatry sessions without my consent;
2. I will inform Dr. Lisa Karabelnik if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Lisa Karabelnik will inform me if any other person can hear or see any part of the session before the session begins.
3. I understand that I MUST be a resident of Connecticut to be eligible for telepsychiatry services from Dr. Lisa Karabelnik.
4. I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to the satisfaction of Dr. Lisa Karabelnik before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Dr. Lisa Karabelnik to use telepsychiatry in the course of diagnosis and treatment.

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Patient or Parent/Legal Guardian Signature (both parents if relevant) Date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s name Relationship to patient Date