Informed Consent for Online Telemedicine

1. Purpose: The purpose of this form is to obtain your consent to participate in a telemedicine session with your provider for medication management and psychotherapy.

2. Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine session.

3. Confidentiality: Reasonable and appropriate efforts have been made to eliminate confidentiality risk associated with telemedicine session. Our office will be using Medent which is HIPPA compliant platform.

4. Rights: You may withhold or withdraw consent to the telemedicine session at any time without affecting your right to future care or treatment with University Psychiatric Practice.

I, ____________________________________ have read the above information and by signing my name I agree to participate in a telemedicine session for medication management and psychotherapy.

Main phone number: ____

E-mail address: ____

X ____________________________________ ____/____/____

Patient Signature *Date of Service*