CORNERSTONE FAMILY HEALTHCARE

845-563-8000 • www.cornerstonefamilyhealthcare.org

Informed Consent for TelePsychiatry/Telehealth Services

Date _____

Patient Name: _____ Date Of Birth: _____ Patient ID#_____

Location of Patients Services: _____

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider.

I understand that the laws that protect the privacy and the confidentiality of patient medical information also apply to telehealth services which may include general medicine and behavioral health. As always, my insurance carrier will have access to medical records for quality review/audits.

I understand that I will be responsible for any copayments or coinsurance that may apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may also revoke my consent orally or in writing at any time by contacting Cornerstone Family Health Care.

TELEPSYCHIATRY: I have been given information regarding the use of Telepsychiatry/ Telehealth and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in telepsychiatry services, in which case evaluations will be conducted in-person by appropriate clinicians. I understand that telepsychiatry services may reduce any delays in services, need to travel or other risks associated with not having the services provided by telepsychiatry/telehealth services. Furthermore, I am made aware that each telepsychiatry/telehealth session shall not be recorded without my consent.

I agree to participate in telepsychiatry/telehealth services.

Signature of patient _____ Date: _____
(Or person authorized to sign for patient)

Witness: _____ Date: _____