TELEPSYCHOLOGY CONSENT FORM

Office of Dr. Ellen G. Kelman

INTRODUCTION

Telepsychology is the delivery of psychological services using interactive audio or audiovisual electronic systems where the Psychologist and the patient are not in the same physical location. Some electronic systems such as regular phone calls, Skype, and FaceTime may not comply with HIPAA, the federal medical privacy law. I can request the use of a system that is compliant.

Potential benefits include increased accessibility to psychological care and convenience. However, there are also potential disadvantages, including that security protocols can fail, causing a breach of privacy of my confidential medical information. Traditional face-to-face meetings are the best alternative to the use of telepsychology and are preferred whenever possible.

MY RIGHTS

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychology. I have the right to withhold or withdraw my consent to the use of telepsychology during the course of my care at any time. I understand that, in this event, Dr. Kelman will work with me to find an alternative form of care. I understand that all rules and regulations that apply to the practice of psychology in the state of Arizona also apply to telepsychology.

MY RESPONSIBILITIES

I will not record any telepsychology sessions without written consent from Dr. Kelman. I understand that Dr. Kelman will not record any of our telepsychology sessions without my written consent. I will inform Dr. Kelman if any other person can hear or see any part of our session before the session begins. Dr. Kelman 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 Dr. Kelman, am responsible for the configuration of any electronic equipment used on my computer which is used for telepsychology. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

PATIENT CONSENT TO THE USE OF TELEPSYCHOLOGY

I have read and understand the information provided above regarding telepsychology, have discussed it with Dr. Kelman and all of my questions have been answered to my satisfaction. By signing below, I am waiving my HIPAA privacy rights if it is my choice to use an unsecure means of communication. I hereby give consent for the use of telepsychology in my care.

Name of Patient_____

Signature of Patient_____

(Or person authorized to sign for patient)

Date_____