UNIVERSITY HEALTH SERVICES
MARY B. COBURN HEALTH & WELLNESS CENTER *at* FSU

Informed Consent for Telepsychiatry Consultation

Patient Name_____ Date of Birth_____

1. I am currently physically in the State of Florida and wish to engage in a telepsychiatry consultation with a psychiatry provider from University Health Services (UHS).

2. The UHS psychiatry provider has explained how the video conferencing technology will be used for this consultation and that it will not be the same as a traditional visit since we will not be in the same room.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.

4. I understand that the UHS psychiatry provider or I can discontinue the telepsychiatry consult if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand my healthcare information may be used for scheduling and billing purposes.

6. I understand my UHS psychiatry provider will conduct the telepsychiatry consult in an area that is private in order to protect my healthcare information.

7. I have had the limitations of and alternatives to a telepsychiatry consultation explained to me.

8. I acknowledge that no guarantees have been made to me as to the effect of diagnosis and treatment through telepsychiatry.

9. Services may include, but are not limited to, psychiatry and psychotropic medication management, short-term psychotherapy and crisis intervention.

10. If family members or significant others are involved in the coordination of care, the psychiatry provider will need the appropriate consent to speak with and share information regarding care.

11. Exceptions affecting the confidentiality of your telepsychiatry are:
    a. clear and present danger to self or others,
    b. court orders, or
    c. abuse of children, elderly or disabled.

12. I have read and had my questions answered regarding items 1-11 above.

13. I understand the risks and benefits of a telepsychiatry consultation and wish to proceed.

Signature of Patient or Parent/Guardian if under the age of 18_____

Printed Name _____Date_____

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