INFORMED CONSENT FOR TELEPSYCHIATRY SERVICES

Patient Name:	Date of Birth:	Date of Consent:
Patient Address: City:	State:	Zip:
Physician Name: *The Happiness Psychiatrist®: Sheenie Ambardar, M.D.*		

INTRODUCTION:

Telepsychiatry & Teletherapy involve the use of electronic communications that enable your health care provider at a different location from you to meet with you, assess your condition, diagnose, and treat you. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the physician conducts a standard evaluation and consultation.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

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BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and in the course of my telepsychiatry interaction, and may receive copies of this information for a reasonable fee,
4. I understand that telepsychiatry may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

I attest that I am located in the state of California and will be present in the state of California during all telehealth appointments with The Happiness Psychiatrist®: Sheenie Ambardar, M.D.

PATIENT CONSENT TO THE USE OF TELEPSYCHIATRY

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care.

I hereby authorize *The Happiness Psychiatrist®: Sheenie Ambardar, M.D.* to use telepsychiatry in the course of my diagnosis and treatment.

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

PHYSICIAN'S SIGNATURE **DATE**