Medical and Mental Health Clinic
1420 Valwood Parkway Ste. 170a
Carrollton, Texas 75006

Informed Consent for Tele-Psychiatric Services

Patient Name: _____ Date of Birth: _____

I. **Introduction.** Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

II. **Consent for Treatment**. I voluntarily request Keturah Health Medical and Mental Health Clinic and such associates to participate in my medical care using telemedicine. I understand that Keturah Health Medical and Mental Health Clinic (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that Keturah Health Medical and Mental Health Clinic Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If Keturah Health Medical and Mental Health Clinic Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

III. **Release of Information**. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to Keturah Health Medical and Mental Health Clinic. I understand and agree that the information I am authorizing to be released may include: 1) Lab test results, diagnosis, treatment, and related

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mental health information. I understand that the disclosure of my medical information to Keturah Health Medical and Mental Health Clinic Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ _____

Signature of Patient/Responsible Party (Relationship to Patient) Date