TELEPSYCHIATRY CONSENT FORM

Telepsychiatry provides psychiatric services using interactive video conferencing tools, similar to Skype or Zoom (but more secure and HIPAA compliant), in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office during this pandemic. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternatives to telepsychiatry include traditional face to face sessions.

Your Rights:

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;
2. I understand that the platform being used (doxy.me) is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of doxy.me at https://help.doxy.me/en/articles/3287752-security-required-services-used-by-doxy-me
3. I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.
4. I understand that Dr. Kim has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time;
5. I understand that all rules and regulations which apply to the practice of medicine in the State of Washington also apply to telepsychiatry.

Your Responsibilities:

1. I will not record any telepsychiatry sessions without the prior written consent of Dr. Kim and I understand that Dr. Kim will not record telepsychiatry sessions without my consent;
2. I will inform Dr. Kim if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Kim will inform me if any other person can hear or see any part of the session before the session begins. This is so that your privacy can be protected.
3. I understand that I must be a resident of Washington to be eligible for telepsychiatry services from Dr. Kim.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Dr. Seong-Hun Kim to use telepsychiatry in the course of diagnosis and treatment

_____

Printed Name

_____ _____

Signature Date