Generations **P**sychiatry **S**ervices
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Generations Psychiatry Services PLLC

Telemedicine Informed Consent

Patient Name: _____________________________ Date of Birth: _____________

I hereby consent to engaging in telemedicine with Generations Psychiatry Services PLLC as part of my behavioral health treatment. I understand that telemedicine includes the practice of psychotherapy, diagnosis, treatment (including the prescribing and managing of psychiatric medications), and transfer of medical data using interactive audio, video, or data communications.

I understand the following rights and limitations associated with telemedicine:

1. I have the right to revoke my consent to telemedicine at any time.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information I disclose during the course of my treatment is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim, and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Generations Psychiatry Services PLLC that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/ or the electronic storage of my medical information could be accessed by unauthorized persons.

I have read and understand the information printed above. I have had the opportunity to discuss it with a staff member of Generations Psychiatry Services PLLC.

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Signature of Patient or Parent/ Guardian Date