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Diana L. Prescott, PhD – Clinical Psychologist
Caring for Women and Children

David L. Prescott, PhD – Clinical Psychologist
Caring for Your Health and Wellness

Telemedicine/Telepsychology Informed Consent Form

______________________________ Patient Name

_______________ Date of Birth

_______________ Medical Record Number

I hereby consent to engaging in telemedicine/telepsychology (e.g. Internet or telephone-therapy) with **Diana L. Prescott, Ph.D.** as part of his/her treatment. I understand that telemedicine/ telepsychology" includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Telemedicine/telepsychology provides convenience and increased accessibility to mental health care when face to face treatment in unavailable or infeasible under some circumstances.

I understand that I have the following rights with respect to telemedicine/telepsychology:

(1) I have the right to withhold or withdraw consent at any time without affecting my/his/her right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of his/her medical information also apply to telemedicine/telepsychology. As such, I understand that the information disclosed by me during the course of his/her therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child abuse; expressed threats of violence towards an ascertainable victim; and intent to commit suicide.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine/telepsychology interaction to researchers or other entities shall not occur without his/her written consent.

(3) I understand that there are risks and consequences from telemedicine/telepsychology, including, but not limited to, the possibility, despite reasonable efforts on the part of my/his/her provider, that: the transmission of my/his/her medical information could be disrupted or distorted by technical failures; the transmission of my/his/her medical information could be interrupted by unauthorized persons; and/or the electronic storage of his/her medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine/telepsychology based services and care may not be as complete as face-to-face services. I also understand that if my/his/her psychologist believes I would be better served by another form of treatment (e.g. face-to-face services) I will be referred to a provider who can provide such services in his/her area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my/his/her efforts and the efforts of my/his/her provider, my/his/her condition may not be improved, and in some cases may even get worse.

(4) I understand that I/he/she may benefit from telemedicine/telepsychology, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my/his/her medical information and copies of medical records in accordance with Maine law.

I have read and understand the information provided above. I have discussed it with my/his/her provider, and all of my questions have been answered to my satisfaction.

____ ______________
Patient Date

____ __________ ______________
Signature of parent/guardian Relationship Date

____ ______________
Signature of Witness/Psychologist Date