Oasis Behavioral Health

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Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as doxy.me, 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 and travel long distance. 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. Alternative 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 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 at http://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 my counselor or prescriber 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 Massachusetts also apply to telepsychiatry.

Your Responsibilities:

1) I will not record any telepsychiatry sessions without the prior written consent of counselor or prescriber and I understand that counselor or prescriber will not record telepsychiatry sessions without my consent;
2) I will inform my counselor or prescriber if any other person can hear or see any part of our session before the session begins. Likewise, my counselor or prescriber will inform me if any other person can hear or see any part of the session before the session begins.

3) I understand that I MUST be a resident of Massachusetts to be eligible for telepsychiatry services from my counselor or prescriber.
4) I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to my counselor or prescriber's satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize counselor or prescriber to use telepsychiatry in the course of diagnosis and treatment.

X_____ X_____

Patient or Parent/Legal Guardian Signature Date

X_____ X_____

Patient's name Relationship to patient