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# TELEPSYCHOLOGY INFORMED CONSENT

## Introduction

Telepsychology is the delivery of psychological services using interactive audio or audiovisual electronic systems where the Psychologist and the patient are not in the same physical location. The interactive electronic systems used in Telepsychology incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. However, these electronic systems may not comply with HIPAA, the federal medical privacy law.

Potential benefits include increased accessibility to psychological care and convenience. However, there are also potential disadvantages, including that security protocols can fail, causing a breach of privacy of my confidential medical information. Traditional face to face meetings are the best alternative to the use of Telepsychology and are preferred whenever possible.

## My Rights

I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telepsychology. I understand that the technology used by Dr. Stroup is encrypted to prevent the unauthorized access to my private medical information. I have the right to withhold or withdraw my consent to the use of Telepsychology during the course of my care at any time. I understand that, in this event, Dr. Stroup will work with me to find an alternative form of care.

I understand that all the rules and regulations which apply to the practice of Psychology in the state of Washington also apply to Telepsychology.

My Responsibilities

I will not record any Telepsychology sessions without written consent from Dr. Stroup. I understand that Dr. Stroup will not record any of our Telepsychology sessions without my written consent. I will inform Dr. Stroup if any other person can hear or see any part of our session before the session begins. Dr. Stroup will inform me if any other person can hear or see any part of our session before the session begins. I understand that I, not Dr. Stroup, am responsible for the configuration of any electronic equipment used on my computer which is used for Telepsychology. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the state of Washington and that I must be physically in Washington State during my appointments with Dr. Stroup in order to be eligible for Telepsychology services from Dr. Stroup

Patient Consent To The Use of Telepsychology

I have read and understand the information provided above regarding Telepsychology, have discussed it with Dr. Stroup and all of my questions have been answered to my satisfaction. By signing below I am waiving my HIPAA privacy rights. I hereby give my informed consent for the use of Telepsychology in my care.

_____ _____

Signature Date

_____

Print Name