Arman Danielyan, M.D.
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Telepsychiatry Consent Form

I hereby authorize Dr. Arman Danielyan to use telepsychiatry for diagnostic and treatment purposes. I understand the risks of using telepsychiatry for my/my child's treatment. I understand that using telepsychiatry involves the communication of my medical information, both orally and/or visually, to physicians and other health care practitioners located in other parts of the State.

I understand I have all the following rights with respect to telepsychiatry:

- I have the right to withhold and/or withdraw my consent to use telepsychiatry at any time during the course of treatment. Withdrawing or withholding my consent will not affect the availability or quality of care I would have received otherwise.
- The confidentiality of protected health information (PHI) laws applies to telepsychiatry as well. I understand that my telepsychiatry sessions will not be video or audio recorded. My PHI will be kept secure and confidential. I also understand that there are both mandatory and permissive exceptions to confidentiality, as mandated by the California State laws, including, but not limited to reporting child and elder abuse; expressed threats of violence towards an identifiable victim etc.
- I have the right to request copies of my medical records, including the psychiatric evaluation and progress notes reflecting the content of the telepsychiatry sessions. I may obtain copies of my medical records for a reasonable fee.
- I understand that there are risks associated with telepsychiatry service including, but not limited to, the possibility of the transmission of the medical information being disrupted or distorted by technical failures; the transmission of my medical information being interrupted by unauthorized persons; and/or the electronic storage of my medical information being accessed by unauthorized persons.

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- I understand that professional service and care provided via telepsychiatry may not be as complete as face-to-face services. I also understand that Dr. Danielyan may recommend to discontinue telepsychiatry and to engage in face-to-face services. I understand that I may benefit from telepsychiatry, but that there may also be worsening of my condition as a result of telepsychiatry treatment.
- I understand that there might be other risks associated with telepsychiatry service that are not listed here, and that I consent to engage in telepsychiatry service provided by Dr. Danielyan.

I have read and understand the information provided above, I have discussed it with my physician or my physician's staff, and all my questions have been answered to my satisfaction

____ Date _______________
Patient signature*

____ Date _______________
Parent/legal guardian (if patient is a minor)

____ Date _______________
Treatment provider