Telepsychiatry Consultation Service - Consent to Participate

PART A

My health Care provider has asked my child and/or myself to participate in the Telepsychiatry service. The purpose of the network is to permit my health care provider to provide health care services to my child using interactive video equipment.

I_________________________ of ________________________ understand this participation means that we will be
(please print parent/guardian name) (Address)
communicating through interactive video equipment with the health care provider.

If this is a consultative visit, I give my consent for me and/or my child to be interviewed by the consultant(s) and authorize the release of any relevant medical information pertaining to my child to this consultant.

This consent is continuous in nature for the provision of Telepsychiatry Services and will remain in effect until revoked in writing by myself.

I have read this document and I hereby consent to my and/or child's participation in the Telepsychiatry services under the terms described above.

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian Signature:	Date:
Mature Minor: (A determine mature minor under the age of 18)	Date:
Witness Signature:	

PART B

Information obtained from school personnel (e.g., teachers, principal) can provide valuable clinical information that would assist the health care provider in the delivery of consultation services. This is accomplished through the completion of a child behaviour checklist completed by the school personnel, which is then forwarded to the health care provider.

□ I give permission to the health care provider to contact my child's school to obtain the required information.

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian Signature:	Date:
Mature Minor: (A determine mature minor under the age of 18)	Date:
School Name/Location:	
School Contact Person:	