PATIENT PORTAL AUTHORIZATION

Authorization to disclose health information via electronic transmission

Patient Name: _____

E-mail: _____

Date of Birth: _____ / _____ / _____

By signing this form, I authorize **EMPLOYEE WELLNESS, P.A.** to communicate via a personal, secured access Patient Portal with me for my medical care and treatment. Employee Wellness, P.A. Care will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers of Employee Wellness, P.A. as a result of the communications:

- **My Personal Health Information**
- **Electronic Displays of Radiological Images (X-rays)**
- **Laboratory Test Results / Pathology Reports**
- **Other Diagnostic Testing**

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this authorization.

- Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- Portal Messages received by us can be forwarded, printed and/or read, and stored by our staff members.
- We advise caution when communicating highly sensitive or personal information via Portal messages.*(i.e. HIV status, mental illness, chemical dependency, and workers compensation issues)*
- Clinically relevant messages and responses will be documented in your medical record. EMPLOYEE WELLNESS, P.A. will not be liable for information lost or misdirected due to technical errors or failures.
- EMPLOYEE WELLNESS, P.A. does not own or have any interest in the Portal website. Our EMR software provides the Portal as a secure conduit in which communication with our data base is managed.
- I understand that I may revoke this authorization at any time in writing to EMPLOYEE WELLNESS, P.A.
- I understand that if I revoke this authorization, it will not apply to any information already released.

I understand that I may refuse to sign this authorization and understand that EMPLOYEE WELLNESS, P.A. cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

_____ _____

Patient or legal guardian signature Date