Authorization to Use of Disclose Protected Health Information via Electronic Media

Patient Name: ____

E-mail Address: ____

Date of Birth: ____

By signing this form, I authorize Treasure Coast Primary Care to communicate via personal, secured access Patient Portal with me for my medical care and treatment. Treasure Coast Primary 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 Treasure Coast Primary Care as a result of the communications:

My personal health information;
Electronic displays of Radiological images (x-rays)
Laboratory Test Results
Pathology reports
Other diagnostic test

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 at Treasure Coast Primary Care can be forwarded, printed and/or read, stored by Treasure Coast Primary Care 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 the medical record.

Treasure Coast Primary Care will not be liable for information lost or misdirected due to technical errors or failures.

Treasure Coast Primary Care does not own or have any interest in the Portal website. Emds Portal is a secure conduit in which communication with our data base is managed.

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to Treasure Coast Primary Care. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this authorization. I also understand that Treasure Coast Primary Care 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 signature: ___________________________________

Date: ___________________________________