PATIENT PORTAL AUTHORIZATION

Authorization to disclose health information via electronic transmission

Patient Name: _____

E-mail: _____

Date of Birth: _____ / _____ / _____

By signing this form, I authorize **Treasure Coast Primary Care / Treasure Coast Urgent Care** to communicate via a personal, secured access Patient Portal with me for my medical care and treatment. Treasure Coast Urgent 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 Urgent 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 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. Treasure Coast Urgent Care will not be liable for information lost or misdirected due to technical errors or failures.
- Treasure Coast Urgent Care 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 Treasure Coast Urgent Care.
- 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 Treasure Coast Urgent 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 or legal guardian signature Date