Patient Portal Access Form

Patient Name: _____ Birth Date ____ /____ /____ Sex: M ☐ F ☐

Parent or Legal Guardian: _____

ACCESS TYPE	WHAT IS REQUIRED
☐ Your minor child (age 13 or younger)	
☐ Your minor child (age 14 to 17)	Page 2 of this form – Authorization to Use and/or Disclose Protected Health Information (signed by patient)
☐ Your adult child (age 18+)	Page 2 of this form – Authorization to Use and/or Disclose Protected Health Information (signed by patient)
Please return Portal Access Forms to the clinic or fax them to 503-291-1584	

RESPONSIBLE PARTY REQUESTING ACCESS

Name: _____ Birth Date ____ /____ /____

Address (if different than patient's): _____

Phone: _____ Email: _____

ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form and the policies regarding the patient portal and those that appear at login. I understand the risks associated with online communications between my provider and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the policies set forth in the log in screen, as well as any other instructions that my provider many impose to communicate with parents via online communications. I understand that the patient portal is an optional service and that Sunset Pediatrics reserves the right to suspend or terminate it at any time and for any reason. I understand and agree with the information that I have been provided.

Responsible Party Signature:_____

Relationship to patient: _____ Date:_____

FOR INTERNAL USE ONLY

☐ Reviewed and verified form. _____ initials
☐ Reviewed and verified Authorization Form for request types 2 and 3. _____ initials
☐ Proxy activated in Aprima _____ initials
Scan forms into Aprima _____ initials

Revised 2/17/17

Portal Authorization to Disclose Protected Health Information

The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect my ability to obtain health care services or reimbursement for services unless this authorization is required to bill my insurance company.

I authorize the disclosure of all information maintained in my Portal Account, including the following specific information as it may pertain to me (the following items must be initialed to authorize access to your Portal Account):

_____ HIV – positive test results and HIV diagnosis

_____ Mental health information and/or records

_____ Genetic testing information and/or records

_____ Other sexually transmitted diseases

_____ Drug/alcohol diagnosis, treatment or referral information. Federal regulations require you to describe how much and what kind of information is to be disclosed: _____

Federal and/or state law may restrict re-disclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing my health information to someone else, and this authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless this authorization is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will remain in effect for so long as I maintain a Patient Portal account. However, if I am under the age of 18, this authorization will expire when I turn 18 years old.

_____

Signature of Parent/Legal Guardian/Patient 18+ Print Name/Relationship to Patient Date

_____

Signature of Patient (14-17years old) **REQUIRED** Print Name Date