PATIENT PORTAL POLICY

WHAT IS A PATIENT PORTAL?

Sunset Pediatrics provides exclusive portal use for established patients. The patient portal is designed to enhance patient - provider communication. The secure portal is a way to view certain health information for child and communicate non-urgent information with our staff.

Some features offered with this service include:

- The ability to view patient demographic information and send requests to our staff to update information. If you have access to more than one child's account, you will need to make updates for each patient individually.
- Health summary information after your visit with the pediatrician
- Patient statements and online payments
- Immunization records
- Upload documents and pictures for the doctor to review
- Message with your provider and medical staff any non-urgent questions

HOW DO I SIGN UP FOR THE PATIENT PORTAL?

Once you have established with Sunset Pediatrics, a patient portal will automatically be created for you and your child. When you come into our clinic for the first time, you will be asked to physically sign the patient portal form. This form can also be found on our website.
If we create a portal for you, you will be emailed a username and temporary password. Once you log in, it will ask you to create a new password.

PATIENT PORTAL IS NOT INTENDED FOR THE FOLLOWING:

- Diagnosis or extended treatment. All advice that is given over the patient portal is for routine, non-urgent inquiries. Should our team need additional information, they will reach out to you. All responses via the patient portal are at the discretion of the physician and their staff. They reserve the right to require an in-person or telehealth appointment to provide a diagnosis and treatment plan.
- Emergency communication. Communication through the portal is restricted to non-urgent issues. If you believe your child is experiencing an emergency, please call 9-1-1 or go to the closest emergency room.

RESPONSES FROM STAFF

Our system will notify us when we have messages. We will respond to the within 24 to 48 business hours.

PROTECTING YOUR CHILD'S PRIVATE HEALTH IINFORMATION:

While we work hard to ensure that all communication through the portal is secure, it is imperative that Sunset Pediatrics has your correct and current email address and that you inform us to any changes to your email. It is your responsibility to make sure your login information is protected from unauthorized persons. If you think someone has learned of your password, please change it or call our office for assistance. Your email address is confidential and protected information. We will never purposefully share this information with a third party.

ACCESS FOR CHILDREN OVER THE AGE OF 14 YEARS OLD:

According to Oregon Law (ORS 109.640 and ORS 109.67), minors 14 years of age or older can consent to treatment without parent consent, and as such, we need to extend confidentiality to those patients as we would an adult. For this reason, patients 14 years of age and older who wish their parent to have access to their patient portal, will be asked to sign a release form granting access to their requested responsible party. Without a signed release form, access to the portal account will be disabled for responsible parties when the patient turns 14 years of age. This form can be found on our website or in our clinic. (Revised: 10/2024)

Sunset Pediatrics, LLC 9155 SW Barnes Road Suite 840 Portland Oregon 97225 I Phone: (503)296-7800 I Fax: (503)291-1584

Patient Portal Access Form (Under 18 years of age)

Sunset Pediatrics, LLC – 9155 SW Barnes Road Suite 840 Portland, Oregon 97225
Phone: (503)296-7800 Fax: (503)291-1584 Email: records@sunsetpediatrics.com

Today's Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

RESPONSIBLE PARTY REQUESTING ACCESS

Person Requesting Access Name: _____

Birth Date: _____ /_____/_____ Sex: ❑M ❑F Relationship to Patient: _____

Address: _____ Apt# _____

City: _____ State _____ Zip _____

Phone: (_____) _____-_____ ❑Home ❑Cell ❑Other _____ Email Address: _____

AGE OF CHILD

❑ **Under** 14 years of age (Requesting party, please initial the protected/sensitive section then continue the bottom of the form to sign & date)

❑ **Over** 14 years of age (Requesting party, please have **your child** initial the protected/sensitive section and then both you and your child's signatures are required at the bottom of the form)

(The following types of sensitive information will NOT be released without INITIALS. If you do not initial the 5 sections or if your child is over the age of 14 years and they do not initial all 5 sections, portal access will NOT be granted**)**

By initialing, I authorize the release of the following protected or sensitive information:

_____ HIV/AIDS Information _____ Birth Control/STI Information _____ Genetic Testing Information

_____ Mental Health Information (Incl. ADHD/Developmental Disability Information) _____ Drug/Alcohol Diagnosis, Treatment, or Referral Information

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

You do not need to sign this authorization. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive healthcare services is if the healthcare services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to 9155 SW Barnes Rd. Suite 840 Portland, OR 97225 Attn: Medical Records Coordinator and state that you are revoking this authorization. Unless revoked, this authorization will remain in effect for as long as I maintain a patient portal account.

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 outlines 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 may impose to communicate 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 has been provided.

❑ I decline portal access for myself and/or child. **(Please sign even if declining authorization)**

_____ _____ _____/_____/_____

Signature of Parent/Responsible party (REQUIRED) Print Name (REQUIRED) Date Signed (REQUIRED)

_____ _____ _____/_____/_____

Signature of Patient (14 years of age and over) (REQUIRED) Print Name (REQUIRED) Date Signed (REQUIRED)