AUTHORIZATION TO WEB-ENABLE FOR THE WELLMED PATIENT PORTAL

I hereby authorize WellMed and Its Affiliated Providers to electronically send communications to me or my Proxy (individual that I authorize to have access to my medical record information) via the WellMed Patient Portal at the e-mail address provided below. If I assign a Proxy for the WellMed Patient Portal, I understand that this individual shall have access to my medical record information. I have assigned this individual access under the Health Insurance Portability and Accountability Act (HIPAA) and have a current signed authorization to release information in my medical file granting access to this individual with an identified expiration date. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from WellMed should I decide against using the patient portal. I understand that it is my responsibility to notify WellMed if there is a change in my email account or I feel that my secure password has been breached. I understand that I can revoke my permission at any time by giving written notice to my provider. Further, I understand that online communications should never be used for emergency communications or urgent requests and that if I have an emergency or an urgent request, I should contact my physician via telephone or call 9-1-1 if there is a life threatening emergency. I agree not to hold WellMed, its provider practices, providers, or any of its staff liable for network infractions beyond its control.

Patient's Name (Please Print) ______________________ Patient's Date of Birth ______________________

Patient's Email Address ______________________

Patient's Signature ______________________ Date ______________________

Proxy's Name (Please Print) ______________________ Relationship to Patient ______________________

Proxy's Email Address ______________________

Proxy's Signature ______________________ Date ______________________

❑ **HIPAA VERIFIED: PROXY IS LISTED**