

# PRIMARY CARE PARTNERS

Your Partner in Health

## Informed Consent to use Patient Portal

Primary Care Partners is now offering this secure, HIPAA compliant tool as a courtesy to our patients. This is an optional service and we reserve the right to suspend or terminate it at any time, we will alert you to any changes as promptly as possible. By signing below, you confirm that you have **received, read, understand, and agree to comply with the “Procedures and Guidelines for using the Patient Portal”**. You also agree not to hold Primary Care Partners or any staff liable for network infractions beyond their control.

### **Privacy and Security**

The patient portal has a secure tunnel connection with our clinic that uses encryption to keep unauthorized people from accessing your health information. To help ensure that our tunnel remains secure we ask that you provide us with your most current private email address and notify the office if it ever changes. Always keep your user ID and passwords secure so only you or someone you authorized can gain access to your information. If you think someone has learned your password, immediately notify our office (Lisa M.) so we can instruct you on how to change it.

Your email address is confidential and protected information. We will protect this information with our best effort as we do with all your medical and personal information.

**PLEASE NOTE:** This patient portal has messaging features; Primary Care Partners would like to ask that the option to send questions for “medical problem” not be used. Our providers would prefer that patients continue to call the office and speak with trained medical professionals. Primary Care Partners does, however, encourage the use of the other messaging options such as billing questions, requesting a future appointment, requesting medical records and any other general information questions.

**To receive a username and password please sign below and return to Primary Care Partners**

**Confidential email (if not already provided)** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
(Each patient must have their own form, ie; mom + 4 children = 5 different forms)

**Print Name of Parent/Guardian requesting access for minor child** \_\_\_\_\_

**I decline online access to my health information**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_