

South Austin Medical Clinic, PA
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Austin, Texas 8745

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AUTHORIZATION to Use or Disclose Protected Health Information via Electronic Media

(Please Print)

Patient Name: _____ Chart # _____

E-mail Address: _____ Date of Birth: _____

By signing this form, I authorize South Austin Medical Clinic (SAMC) to communicate via personal, secured access Patient Portal with me for my medical care and treat. SAMC 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 health care providers of South Austin Medical Clinic as a result of the communications:

1. My personal health information;
2. Electronic displays of Radiological Images (x-rays)
3. Laboratory Test results
4. Pathology reports
5. Other diagnostic test results

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.

1. Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
2. Portal messages received at South Austin Medical Clinic can be forwarded, printed and/or read, stored by SAMC staff members.
3. 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.)
4. Clinically relevant messages and responses will be documented in the medical record.
5. SAMC will not be liable for information lost or misdirected due to technical errors or failures.
6. SAMC does not own or have any internet in Portal website. E-mds Portal is a secure conduit in which communication with our database is managed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing, and address it to South Austin Medical Clinic. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization. I also understand that South Austin Medical Clinic 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.

Signature

Date: _____