HEALTHCARE ASSOCIATES IN MEDICINE, P.C.

PATIENT INTERNET ACCESS AUTHORIZATION INFORMATION

Dear Patient:

In an ongoing effort to continue to provide you with the best and most comprehensive health care, we are now offering our patients the ability to access their medical information online. This includes, but is not limited to:

- Summaries of your office notes
- Exchange of educational materials with your physician
- Exchange of personal health information (PHI) with your physician
- Instructions on your own personal health care with your physician
- Authorizations
- Referrals
- Notes to return to work or school
- Information on new services available

Due to the confidentiality of this matter, you will need to completely fill out the attached form. Please choose a preferred user name (to use as a log-in) as well as a password (both the log-in and password must be 6 to 12 characters in length and are case sensitive). Sign the form and submit it to your receptionist. This information will then be registered with our portal and you will immediately be able to log-in.

To access your information, just visit our website at www.hca-si.com. There is a link on the main home page (Patient Portal Log-In) for you to click on. This will bring you to a portal prompting you to insert your user name and password. From there you can access your information. **Please note, this portal is a protected and secure location.** You will receive a message at your personal e-mail address notifying you of any new messages submitted on the portal. You must have an e-mail address to utilize this feature.

If you have any questions or concerns, please ask your receptionist.

Sincerely,

Healthcare Associates in Medicine, P.C.

HEALTHCARE ASSOCIATES IN MEDICINE, P.C.

PATIENT INTERNET ACCESS AUTHORIZATION FORM

Please ***print*** all information ***clearly***.

Patient Name	Date of Birth	E-mail Address

Requested User Name/Log-In (must be 6 to 12 characters and is case sensitive)	Password (must be 6 to 12 characters and is case sensitive)

I hereby request that I be given access to my Healthcare Associates patient record as may be made available to me by my physician. I understand that these records are confidential and protected under the Health Information Portability and Accountability Act (HIPAA). Any disclosure of these records to any other individual, organization or other party I fully accept as my full and complete responsibility. I further understand that by accessing this information through the Internet I may compromise the confidentiality of my records and I hereby accept this responsibility and hold my patient, my physician's staff and Healthcare Associates harmless and without any responsibility as a result of their acts of commission or omission in protecting my personal medical record as may be accessible through the Internet. I further understand that this authorization does not limit or otherwise remove the responsibility of Healthcare Associates to protect my records in accordance with HIPAA.

I hereby give my permission, consent and authorization to the Healthcare Associates office and my physician to provide me with personal access to my medical record and accept the risks and responsibilities that may exist in my having this access and ability to view my medical records via the Internet. I understand that my e-mail address may be used to notify me of information or data available and I understand that it is my sole and individual responsibility to access, read or otherwise acquire any information that may be made available through e-mail notification or through my accessing my information on the Internet. I understand that I must have an e-mail address to access this feature.

Agreed: _____ _____

Patient's Signature **Date**

FOR OFFICE USE ONLY– Please select the method of verification. Circle all that apply.

Picture ID Verified↑

HIPAA form Verified ↑

SSN & DOB Verified ↑

Please initial once the patient has been entered here: Entered in Computer _____