Patient Portal Policy and Procedures

Do Not use portal to communicate if there is an emergency.

Proper subject matter:

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc) are not permitted
- We do not refill controlled substance medications drugs on patient portal. You can request a refill but must come in to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message.

Current functionality of Patient Portal:

- Email and secure messaging for Non-urgent needs
- Refill request (must include pharmacy info)
- Viewing of labs results that have been sent to you.
- Viewing and printing of continuity of health records
- Viewing and updating health information
- Viewing of selected health information (allergies, medications, current problems, past medical history). Note you can make changes/ additions to your health records, medication list, etc, but this will not change your permanent records without our review of the information,
- Referral requests
- Appointment request
- Billing questions
- Updating demographic information (address, phone #) and insurance information.

All communication via portal will be included in your chart: Privacy:

- All messages sent to you will be encrypted.
- Message from you to the staff should be through this portal or they will not be secure
- We will keep all email lists confidential and will not share this info with other parties.
- Any member of our staff may read your message or replay in order to help the Physician that has been email. This is similar to how a phone message is handled.
- Our system will check when message are viewed, so you do not have to replay that you have read it

Response time:

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need immediate response.

Patient and Family request for Patient Portal

I hereby request access to the patient portal maintained by Dr. Scott McDowall for the patient named below. I understand that Dr. Scott McDowall office take seriously its responsibility to safeguard the privacy of its patient and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign on and password that I am assigned and will not share my log in information with anyone else. I agree that Dr. Scott McDowall will not be liable for any disclosure of information due to the unauthorized use of my sign on and password. If I feel my sign on and password combination has been compromised, I will contact Dr. Scott McDowall immediately or go to the portal and request a new password.

I understand that is the patient portal will allow me to view my records for the patient. If I accidently gain access to another patient information, I will cease to view it and contact Dr. Scott McDowall immediately. In no event, will I deliberately attempt to access information for any person other than myself. I represent to Dr. Scott McDowall that I am personal representative of the patient with the right to access the patients' health information, or the patient has expressly authorized me to have access. If my status as a personal representative change so that I no longer have such rights, or if the patient authorization expires or is revoked, I will immediately cease using the patient portal to access the patient information and will notify Dr. Scott McDowall.

Patient Name (print): _____

Email address: _____

DOB: _____

Patient Signature: _____

Parental Guardian: _____

OR

_____ **Patient does not have an email address or Does not want access to patient portal**

Scott D. McDowall, M.D.
100 Whetstone Place Suite 206, St. Augustine, Florida 32086 PH: 904-429-9892 FX 904-217-7631

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____
Address: _____
City/State/Zip Code: _____
Patient's Phone: ( ) _____ - _____

☐ I authorize **Dr. Scott McDowall** to ***release*** my medical information to:

Name of Provider or Facility _____
Address _____
City, State, Zip Code _____
Phone# (include area code) _____
Fax# (include area code) _____

OR

☐ I authorize **Dr. Scott McDowall** to ***obtain*** my health information from:

Name of Provider or Facility _____
Address _____
City, State, Zip Code _____
Phone# (include area code) _____
Fax# (include area code) _____

PURPOSE FOR THIS REQUEST: (check one)
☐ Healthcare ☐Personal ☐Transfer of Care ☐Other Explain: _____

TYPE OF RECORDS REQUESTED: (Check One)
☐ All medical records related to a specific illness or injury.

_____
Specify illness/injury Date(s) of treatment

☐ Treatment Summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Immunization History
☐ Specific information (Select one or more as applicable):
☐ Procedure Report ☐ History & Physical ☐ Laboratory test results ☐X-ray reports ☐ HIV/AIDS
☐ Psychiatric/Psychological evaluations/treatments ☐ Drug and Alcohol Treatment Information
☐ Other: _____
☐ Copy of entire medical record as allowed by law.

AUTHORIZATION VALID FOR: (Check One)
☐ This request only.
☐ One year from the date of this authorization **OR** _____. (Insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **AND** for medical records of any **future** treatment of the type described above until _____(insert date)

I understand that:

- My right to healthcare treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address below except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by federal privacy regulations, the information stated above could be re-disclosed.
- Authorization for Release of HIV/AIDS related information, mental health, or substance abuse diagnosis and treatment information will expire in **60 days.**
- There may be a charge for the request records.

Signature of Patient/Legal Representative _____ Date: _____

Printed Name of Signer: _____

Relationship to Patient: _____