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 messages 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.

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.

Email address: _____ **Patient Signature:** _____

OR

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

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/ or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/ information.

If at any tine I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/ information at that email or text address from the practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ feedback/ health information unless I request a change in writing (see revocation section below).

The cell phone number I authorize to receive text message for appointment reminders. Feedback and general health reminders/ information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/ feedback/ information is _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Signature: _____ Date: _____

Revocation:

_____ I hereby revoke my request for future communications via emails and/ or text messages.

_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

Note: This revocation only applies to communications from this practice.

Patient Name: _____

Patient/ Patient Representative Signature: _____

Date: _____

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:

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)

_____
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, following the Rule 64B8-10.003, Florida Administrative Code.
- For the first 25 pages, the cost shall be $1.00 per page.
- For each page more than 25 pages, the cost shall be $0.25 each. (please allow 7 business day for processing)

Signature of Patient/Legal Representative_____ Date:_____

Printed Name of Signer: _____

Relationship to Patient: _____