Portal Family Access

For patients with Special Healthcare Needs

The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect my ability to obtain health care services or reimbursement for services unless this authorization is required to bill my insurance company.

Patient Name:	Address:
Patient DOB:	
Provider Name:	Phone:

Release Purpose: Access to my ezAccess Patient Portal record
Request Type:

☐	Minor child is 14 to 18 years old	Authorization signed by patient must be in place **
☐	Adult child over age of 18	Authorization signed by patient must be in place **

*** If patient is unable to grant access, legal documentation showing authority to access protected patient information is required*

Giving access to:

Name:	Address:
DOB:	
Relationship to Patient:	Preferred Phone:

I authorize the disclosure of all information in my electronic medical record, including the following specific information as it may pertain to me. Each of the following items must be initialed to authorize access to your portal account:

____ HIV-positive test results and HIV diagnosis
____ Mental Health information and/or records
____ Genetic testing information and/or records
____ Other sexually transmitted disease
____ Drug/alcohol diagnosis, treatment, or referral information (Federal regulations require you to describe how much and what information is to be disclosed: _____

- Federal and/or state law may restrict re-disclosure of HIV-positive tests and HIV diagnosis, other sexually transmitted disease information, mental health information, genetic information, and drug/alcohol diagnosis, treatment, or referral information.
- My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless this authorization is necessary to determine if I am eligible to enroll in the health plan.
- I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will remain in effect for so long as I maintain my portal account. However, if I am under the age of 18, this authorization will expire when I turn 18 years old.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient/Legal Guardian	Print Name/Relationship to Patient	Date
Signature of Patient ☐ Patient Unable to Sign	Print Name	Date Provider Approval:_____