GENERATIONS
Primary Care
270 Burley Avenue ♦ Hopkinsville ♦ KY ♦ 42240
Telephone: 270-887-6767

Patient Portal/Patient-Provider E-mail
Authorization to Use or Disclose Protected Health Information via Electronic Media

Patient Name: _____ Date of Birth: _____

Email Address: _____

By signing this form, I authorize Generations Primary Care (GPC) to communicate via personal, secured access Patient Portal with me for my medical care and treatment. GPC will provide notices via my personal e-mail that information can be found in my Patient Portal. No personal health information is transmitted via or into my personal e-mail. I understand that the following types of protected health information may be used, disclosed and retained by the health care providers of GPC 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 healthcare provider 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 GPC can be forwarded, printed and/or read, stored by GPC 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 worker compensation issues.)
4. Clinically relevant messages and responses will be documented in the medical record.
5. GPC will not be liable for information lost or misdirected due to technical errors or failures.
6. GPC does not own or have any interest in the 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 Generation Primary Care. 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 Generations Primary Care 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 _____