

PATIENT NAME _____ **DATE OF BIRTH** _____

TEXAS HILLS URGENT CARE CENTERS

Patient Portal Authorization Form

By signing this document I agree to abide by the ethical and legal responsibility to protect the confidentiality of health records. I agree to use the patient portal only to access my own health records, and/or those of my own minor children or those for whom I am the durable power of attorney for health care. If I become aware of a breach, for whatever reason, of this confidentiality, I will report it to Texas Hills Urgent Care Centers expeditiously.

Further, I acknowledge that this portal is intended as a convenient service, and not a replacement for in-person health care. I understand that it is inappropriate and dangerous to use this portal for emergency diagnosis or treatment. For non-emergent issues, if I do not receive a response within the expected time-frame, I agree to contact Texas Hills Urgent Care Centers by conventional means, such as by phone or in person.

Should I, for whatever reason, gain access to another person's health records, I agree to not read such information and I agree to report the problem immediately to Texas Hills Urgent Care Centers.

I understand that I have a responsibility to protect my own log in and password information, and that Texas Hills Urgent Care Centers will not be held liable for breaches of confidentiality arising from unauthorized use of such information. I understand that I must inform Texas Hills Urgent Care Centers of changes in my email address and must keep it updated in the Patient Portal in order to maintain updated medical data.

Signature of Patient/Legal Guardian

Date

Print Patient's name (and Signatory if other than patient)

e-mail address (please print legibly)