

Indiana Surgical Associates, P.C. Patient Portal

ELECTRONIC HEALTH RECORD ACCESS/COMMUNICATION INFORMED CONSENT

I hereby request access to Indiana Surgical Associate's (ISA) Patient Portal and understand that in order to gain access to ISA Patient Portal I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of ISA Patient Portal is subject to certain terms and conditions. I agree to review ISA Patient Portal terms and conditions before accessing ISA Patient Portal and further agree that by accessing ISA Patient Portal I am agreeing to abide by the ISA Patient Portal terms and conditions.

I agree to abide by the guidelines for the ISA Patient Portal electronic communication, as outlined below. ISA Patient Portal is not intended for critical or time sensitive communication. I understand that I am to contact the hospital, office, or physician directly for any urgent or emergent situations. My failure to adhere to the following guidelines may result in termination of the ISA Patient Portal access. When using ISA Patient Portal I agree to never use ISA Patient Portal to communicate information related to behavioral/mental health, chemical dependence, such as alcohol and substance abuse or workers' compensation injuries or disabilities.

I understand that the hospital, office, or provider or a designated staff member will maintain certain activities with ISA Patient Portal as part of the practice medical record, use reasonable and appropriate security practices to protect electronic patient information and prevent unauthorized access (password protection, encryption, proxy authorizations, etc.) and share ISA Patient Portal communications with hospital or office staff and other healthcare providers as needed.

I understand that e-mail is not a confidential means of communication. I agree to waive any rights that I may have against Indiana Surgical Associates, P.C., any affiliated organization, or physician, or the supplier or operator of ISA Patient Portal, for any loss of information due to technical failures and/or unintended breach of confidentiality, due to unauthorized access to my information, as a result of my decision to communicate with my physician in this manner.

For minors ages 12 to 18 this acknowledgment and approval expires on my eighteenth birthday or my written notice to ISA that I have obtained the right to consent on my own behalf.

Patient Acct#: _____

Patient Name: _____

Date of Birth: _____

Last 4 digits of Social Security Number: _____

Patient Signature: _____

Date: _____

If Minor, Parent/Guardian Signature: _____