Medical Associates of Mendham
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Authorization to use patient portal for communication of patient information

Patient Name: _____________________________________ Date of Birth:____________________

Email address: ____________________________________

By signing this form, I authorize Medical Associates of Mendham to communicate by a secured access patient portal with me for my medical care. You will be notified via your person email when information can be found in your patient portal. No personal health information is transmitted via or into your person email. It is understood that the following types of protected health information may be used, disclosed and retained by health care providers of MAM as a result of the communications: My person health information, laboratory test results, pathology reports, other diagnostic test results.

How the portal may be sued by the patient:

- Use the message function to communicate with the staff
- View results of lab or other diagnostic tests
- Receive appointment confirmations
- Request medication refills or ask a billing question
- View health summary information in my chart
- Print or save an electronic copy of the health summary

How the portal may be sued by the staff:

- Communicate with patients through messages received via the patient portal
- Send results of lab or other diagnostic tests to the patient via portal and include messages related to the results
- Receive requests for medication refills and billing questions

Patient and /or personal representative who want to communicate with their healthcare provider by portal should consider all of the following issues before signing the authorization.

1. Portal communication is a convenience and not appropriate for emergencies or time sensitive issues.
2. We advise caution when communicated highly sensitive or personal information via portal messages.
3. Clinically relevant messages and responses will be documented in the medical record.
4. MAM will not be liable for information lost or misdirected due to the technical errors or failures. 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 Medical Associates of Mendham.

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 provide treatment, payment or medication records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

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Signature /Date