Authorization For Disclosure of Protected Health Information Using Patient Portal

All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize Stephen B. Trammell, DO, PA to use/disclose my individually identifiable health information to the Patient Portal (which may include information concerning treatment for office visits, drug/alcohol abuse or use, mental health, HIV status, sexually transmittable diseases, lab tests results, if applicable).

Please Print your legal first, middle and last name:

____

Date of birth: ____________________________

Print mailing address: ____

Please print email address where patient portal messages will be sent:

____

Print Names and relationship to you that can be allowed to see your information if requested:

1. Name:_______________________________________ Relationship: ____________________
2. Name:_______________________________________ Relationship: ____________________
3. Name: _______________________________________Relationship:____________________

I understand that my health care and the payment of my health care will not be affected if I do not sign this form.
I understand that this authorization and information on it may be revoked in writing and delivered to the office in DeSoto or Ovilla requesting my account be inactivated
Stephen B. Trammell, DO, PA and staff will not be responsible for a breach of this information if the patient is using the portal on a computer workstation or device that could be compromised.

____ _____________________ ________________
Signature Relationship Date