| E. Thomas Arne Jr., D.O., F.A.C.C.  1250 S. Tamiami Trail Suite 401  Sarasota, Florida 34239  Office: 941-366-2194 Fax: 941-366-7025  [www.gulfshorepc.com](http://www.gulfshorepc.com) |  |  | IMG_4682 |
| --- | --- | --- | --- |

**REQUEST & AUTHORIZATION TO ACCESS GULFSHORE PERSONALIZED CARE PATIENT PORTAL**

Page 1 of 2

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Gulfshore Personalized Care to provide access to my patient health information via the Patient Portal to the following listed below:

**Patient Patient Email**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Self – (Patient) |  | @ |  | .COM |

**Name -Other**

|  |  |  |  |
| --- | --- | --- | --- |
|  | @ |  | .COM |

**Address City State Zip Code**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**Telephone Number**

|  |
| --- |
|  |

**REQUEST & AUTHORIZATION TO ACCESS GULFSHORE PERSONALIZED CARE PATIENT PORTAL (Continued)**

Page 2 of 2

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby request and authorize my protected health information be made available to me or another individual as designated above through the patient portal. I understand that the information available to me through the portal provides a view of only a portion of my medical record data and information and is in no way intended to represent my complete medical record. I understand that sensitive information which has special protection under Florida law, such as certain diagnostics test results, will not be available through the patient portal. By authorizing this access:**

* **I understand I can request a complete copy of my medical records and or any specific documents which are not available to me by contacting the office directly. These records will be provided within 30 days upon completion of the HIPPA – compliant patient authorization.**
* **I understand maintaining the security of my user name and password to access the Patient Portal is my responsibility.**
* **I understand that access to my electronic health record either to myself or another individual includes the ability to print my patient information.**
* **I understand that I may refuse to sign this authorization and that my refusal to sign WILL NOT affect my ability to obtain treatment from Gulfshore Personalized Care.**
* **I understand I may revoke this authorization at any time by written request to the office.**

**By signing below, I acknowledge that I have read and understand this authorization form.**

**Patient or Legal Representative’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Representative Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Note: Legal documentation for authorized representative is required.**