LEE FAMILY PRACTICE & ASSOCIATES

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Patient Portal Consent Form

The Lee Family Practice Patient Portal is a secure online source of confidential medical information for patient. If you would like access to your medical records via the Patient Portal, please complete this form. If you would like to decline access to the Patient Portal, please check the appropriate box below and sign.

Patient name: ____

DOB: ______________________ **Last 4 Digits of SSN:** ______________________

Secure Email Address: ____

I agree to the following:

1. I will abide by all terms and conditions of the Lee Family Practice Patient Portal.
2. Lee Family Practice is not responsible for any breach of information caused by patient misuse.
3. I understand that my activities within the Patient Portal will become part of my medical record.

I understand the following:

1. Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.
2. All communication is sent to the nursing staff, not directly to the provide. You will receive a response within 24-48 hours.
3. The Patient Portal is NOT a substitute for office visits with your provide and prescription requests for medications not currently being prescribed will NOT be honored. I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal.

☐ I choose **NOT** to participate in Patient Portal at this time because:

☐ *I do not have an E-mail address*

☐ *I do not wish to share my E-mail address*

☐ *Other* ______________________________

SIGNATURE: ______________________________ **DATE:** ______________________

(If not signed by patient please fill out the next section)

REPRESENTATIVE SIGNATURE: ______________________________ **DATE:** ______________________

RELATION TO PATIENT: ______________________________