Backus Hospital
A Hartford HealthCare Partner

ROID

Request and Authorization to Access Backus Hospital's Patient Portal

Patient Information

Patient's Name: _____

Parent's Name (if minor): _____

Patient's Date of Birth: _____

Patient Address:
_____
Street
_____
City/State/Zip
Telephone: _____

I hereby authorize the Backus Hospital to provide access to my patient health information via the Patient Portal to:

☐ Self (Patient/Authorized Representative)
Email Address:_____@_____

☐ Other Individual/Proxy (Please provide name/address in next box)
Email Address:_____@_____

Other Individual/Proxy:

_____
Name
_____
Street
_____
City/State/Zip
Telephone: _____

Authorization

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 in no way is intended to represent my complete hospital medical record. I understand that sensitive information which has special protections under Connecticut law, such as certain diagnostic 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 record and/or any specific documents which are not available to me by contacting the Health Information Management (Medical Record) Department and will generally be provided that information within 30 days upon completion of a HIPAA-compliant patient authorization.
- I understand maintaining the security of my user name and password to access My Health Portal is my responsibility.
- I understand I may authorize a proxy to view and interact with My Health Portal based on specific privileges I assign within the patient portal. I acknowledge and accept responsibility for the decision to provide other individuals of my choosing with access to my protected health information which could be potentially sensitive.
- I understand as a proxy and legal guardian that Backus will end access to the Patient Portal when the minor turns 13.
- I understand access or privileges I give to someone can be modified or removed by myself at any time.
- 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, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule (HIPAA), the information used as described above may be re-disclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal laws may prohibit the recipient from re-disclosing specially protected information, such as substance abuse treatment, HIV/AIDS-related information, and psychiatric/mental health 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, payment, enrollment or eligibility for benefits at Backus Hospital.
- I understand I may revoke this authorization at any time by writing to the hospital, Attention: Privacy Officer except to the extent that action has been taken in reliance thereon.

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

Patient or Legal Representative's Signature:_____Date:_____

Legal Representative Printed name: _____Relationship to patient:_____

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