REQUEST AND AUTHORIZATION TO ACCESS PATIENT PORTAL (My eCare)

Patient Information

Patient's Name: _____ Patient's Address: _____

Parent's Name (if minor): _____ Street: _____

Patient's Date of Birth: _____ City/State/Zip: _____

Last 4 digits of SSN: _____ Telephone: _____

I hereby authorize South Central Regional Medical Center to provide access to my patient health information via My eCare Patient Portal to: ***(Check only one option)***

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

OR

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

Complete this section only if you checked **Proxy/Other Individual**

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 (My eCare). 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. 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 in My eCare 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 eCare is my responsibility.
- 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 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 they my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits at South Central Regional Medical Center.
- I understand I may revoke this authorization at any time in writing 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:_____
*Legal documentation to represent you as an authorized representative (if applicable) is required.

☐ Registration Completed Date: _____ MR#_____ Clerk Initials: _____

DO NOT WRITE BELOW THIS LINE

SOUTH CENTRAL REGIONAL MEDICAL CENTER
PO BOX 607, LAUREL MS 39441

PRTLAUTH

PATIENT LABEL HERE