

## PORTAL ACCESS CONSENT & AGREEMENT

- I have been provided information about the North Idaho Hospital Patient Portal (Portal), which includes data from Boundary Community Hospital, Bonner General Health, and Kootenai Health.
- I understand that my personal health and individually identifying information is available to me via the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information. To permit this access, a specific request will need to be made through the medical records department.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use at the time of sign-up.
- If I refuse to accept the portal at this time, I understand that I may change that decision in the future and can contact the Boundary Community Hospital Medical Records department to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

I want to access the Portal to view my medical records. I understand the consent & agreement above.

Patient name (please print): \_\_\_\_\_

Patient date of birth: \_\_\_\_\_ Email address: \_\_\_\_\_

<b>Patient Signature:</b> _____	Date	Time
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Medical Records Staff Only
Medical Record #: _____
Email entered in MPI by: _____
MPI entry date: _____
Portal access created on: _____
Access completed by: _____
Scan date: _____ by: _____

Patient Label



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