Patient Consent Form

1. I understand the risks and benefits of having my information in Wellport. I know that Wellport does not replace speaking or meeting with my physician or other healthcare clinicians.

2. I release any and all of my personal health information (including information I might consider sensitive) from any participating health care provider delivering my health care for the purpose of creating my Clinical Health Summary and Personal Health Summary. This includes physicians, nurses, hospital professionals, nursing home and home health professionals, and other clinicians when appropriate to my health care.

3. I understand and accept that my Personal Health Summary is not my official medical record, and that it might be incomplete (it might not contain all of the information that the hospital or each of my doctors may keep regarding the care that I receive) or inaccurate (it might not contain the most recent or corrected information about me).

4. I understand and accept that neither my Clinical Health Summary nor my Personal Health Summary is an official medical record. My physician and other clinicians are not required to be aware of the contents of my Clinical and Personal Health Summaries. They may not access it unless they have a "need-to-know" at the time they are involved in my care.

5. I understand and accept that if I wish to receive a copy of, or access to, information that is a part of my official medical record, I must contact my clinician or other provider about how I can make such a request.

6. I understand and accept that I am responsible for maintaining the secrecy of any user name and password I am provided to access my Personal Health Summary or to allow my designated Authorized Representative to access my Personal Health Summary. If I misplace my username and/or password or think that someone might have gained access to my Personal Health Summary who should not have access, I shall notify Wellport immediately.

7. I understand and accept that neither Wellport nor any of my clinicians nor other providers are liable for any unauthorized access to my health information that may result from my not keeping my username and password secret.

8. I understand that I am not required to have a Clinical Health Summary nor to activate a Personal Health Summary. Clinicians and other providers may not withhold treatment because I don't share my health information with Wellport.

9. I understand that I have the right to change my mind and stop sharing my health information. I may "cancel" or deactivate my Clinical and Personal Health Summaries at any time by completing "Request to Withdraw Permission for Sharing of Health Information" available at www.wellporthealth.net.

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10. I agree and accept that neither Wellport nor any of my clinicians nor other providers is obligated to make a Personal Health Summary available to me, and if Wellport chooses to end its Personal Health Summary technology for any reason, then I will no longer have access to my personal health information through a Personal Health Summary.

11. I understand that Wellport will use the Massachusetts Health Information Highway (Mass HIway) to share clinical and administrative information with appropriate clinicians in more distant locations. Some of this information may be considered sensitive. I permit the sharing of my clinical and administrative information with other clinicians and insurers appropriately involved in my care over the Massachusetts Health Information Highway or by another secure encrypted (coded) communication method. I permit the Mass HIway to list which clinicians have provided my care.

12. I hereby accept and confirm that information about the risks and benefits of using Wellport is available to me at www.wellporthealth.net.

13. I understand that some of the personal health information released may contain:
    - HIV test results and other information about sexually transmitted diseases
    - Genetic Screening test results
    - Reproductive health concerns and any pregnancy history including abortion
    - Alcohol and Drug Abuse Records
    - Details of Mental Health Diagnosis and/or Treatment
    - Social, family, and interpersonal issues mentioned during an office visit

_____ _____

Signature of Patient (age 12 and over) Date of Signatures

_____ _____

Signature of Parent or Guardian (for all patients under age 18) Relationship to Patient

_____

Print Patient Name

_____ _____

Patient Date of Birth Patient's email address

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