



# Community Family Practice, PA

The patient portal is a secure web portal that allows you as a patient to access medical records via the internet. This is not mandatory for our patients, but is an optional service that we offer. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal can provide the following services:

1. Medication refill request.
2. Communication of laboratory results from staff to patient.
3. Review a patient's medical summary, medication list, treatment history and visitation dates.
4. Limited communication regarding ongoing treatment.

The Patient Portal is provided as a courtesy to our valued patients. While some offices charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of Patient Portal persists, we reserve the right at our own discretion to terminate Patient Portal offering, suspend user access or modify services offered through the Patient Portal.

If you are interested in participating in the Portal, please read the following policy carefully and sign at the bottom of the page:

1. We are offering the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent.
2. Please note that the portal is not checked or updated on weekends.
3. We do not refill controlled substances over the portal.
4. If you find you are not receiving emails from us, please check your JUNK email folder before contacting us.
5. By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Community Family Practice responsible for any network infractions beyond our control.

Your signature below confirms that you have read and fully understand our policies for online communication and wish to participate in our patient portal.

Name \_\_\_\_\_

Email address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_