MEDICAL EXCHANGE OF INFORMATION

I HEREBY AUTHORIZE SOUTHERN SURGICAL, PC TO STORE MY INFORMATION ELECTRONICALLY AND TO EXCHANGE THIS INFORMATION WITHIN THE MEDICAL COMMUNITY (E.G. PHARMACY, LABORATORY, HOSPITAL, REFERRING PHYSICIAN) TO CONTINUE MY MEDICAL CARE.

PATIENT PORTAL AND EMAIL CONSENT

I AGREE THAT I MAY BE PROVIDED WITH AN OPPORTUNITY TO PARTICIPATE IN AND/OR USE THE SOUTHERN SURGICAL PC PATIENT PORTAL AND THAT THE EMAIL ADDRESS I PROVIDE AT REGISTRATION MAY BE USED FOR PATIENT PORTAL COMMUNICATIONS AND ACCESS. I AM PROVIDING CONSENT FOR THE SOUTHERN SURGICAL PC TO COMMUNICATE WITH ME REGARDING MY PROTECTED HEALTH INFORMATION VIA THIS PATIENT PORTAL. I UNDERSTAND THAT MY HEALTH INFORMATION IS PROTECTED BY FEDERAL AND STATE LAW. THIS CONSENT APPLIES TO RECORDS WHICH MAY CONTAIN INFORMATION RELATED TO TESTING, DIAGNOSIS, OR TREATMENT FOR CONDITIONS INCLUDING, BUT NOT LIMITED TO, DRUG AND ALCOHOL ABUSE, PSYCHOTHERAPY, MENTAL, OR OTHER BEHAVIORAL HEALTH, HIV/AIDS, OR OTHER COMMUNICABLE DISEASES; GENETIC TESTING, OR ANY OTHER CONDITION EXPRESSLY PROTECTED BY GEORGIA LAW. THIS CONSENT WILL REMAIN IN EFFECT UNLESS I DEACTIVATE MY (PATIENT PORTAL) ACCOUNT OR PROVIDE WRITTEN NOTICE TO SOUTHERN SURGICAL, PC.

I UNDERSTAND THAT MY USERNAME AND PASSWORD WILL BE UNIQUE TO MY HEALTH INFORMATION AND SHARING MY USERNAME AND PASSWORD MAY GRANT OTHERS ACCESS TO MY HEALTH INFORMATION. I FURTHER UNDERSTAND THAT ANY HEALTH INFORMATION DISCLOSED AS A RESULT OF SHARING MY USERNAME AND PASSWORD MAY NO LONGER BE PROTECTED UNDER FEDERAL OR STATE LAW AND COULD BE FURTHER RELEASED BY THE INDIVIDUAL WHO RECEIVES THE INFORMATION.

DATE_______________________________ SIGNATURE_______________________________________