Associates in Foot and Ankle Care, INC
1007 Spring Creek Road
Chattanooga, TN 37412

Dr. Dennis L. Bizzoco, DPM
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Authorization to Use or Disclose Protected Health Information via Electronic Media

(Please Print)
Patient Name:______________________ Date of Birth:__________

E-Mail Address:______________________________
By signing this form, I authorize Associates in Foot and Ankle Care to communicate via personal, secu **red** access patient portal with me for my medical care and treatment. Associates in Foot and Ankle Care will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed and retained by health care providers of Associates in Foot and Ankle Care as a result of their communications.

1. My personal health information
2. Laboratory Test results
3. Pathology reports
4. Other diagnostic test results

Patients and /or Personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this Authorization.

1. Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
2. Portal messages received at Associates in Foot and Ankle Care can be forwarded, printed and /or read, stored by Associates in Foot and Ankle Care staff members
3. We advise caution when communicating highly sensitive or personal information via Portal Messages.
4. Clinically relevant messages and responses will be documented in the medical record.
5. Associates in Foot and Ankle Care will not be liable for information lost or misdirected due to technical errors or failures.
6. Associates in Foot and Ankle Care do not own or have any internet in Portal website. E-mds Portal is a secure conduit in which communication with our database is managed.

I understand that I have a right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing and address it to Associates in Foot and Ankle Care. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this Authorization. I understand that I may refuse to sign this authorization. I also understand that Associates in Foot and Ankle Care cannot deny or refuse to provide treatment, payment or medical records if I refuse to sign this Authorization.

I have read and understand the information in this authorization form

Signature______________________ Date______________