

Secure Message Patient Portal Access Request Form



Thank you for your interest in Secure Message Patient Portal, an easy-to-use Internet tool that provides you with timely and secure electronic access to your DFD Russell Medical Centers health information from anywhere and anytime.

Instructions for completing this form:

To sign up for access to your health information in Secure Message Patient Portal, please complete this Access Form and return it to one of the DFD offices in Leeds, Monmouth or Turner.

Patient Portal services are available to active DFD Russell Medical Centers' patients over the age of 18.

You will be required to present a photo ID.

Patient's Information: (All sections required – Please print clearly)

Full Name: _____

Date of Birth: _____

Last Four Digits of Social Security #: ____ ____ ____ ____

Telephone #: _____

Secure Message Patient Portal (SMPP) Terms and Agreement: **(Please initial each)**

- ____ I understand that SMPP is intended as a secure online source of confidential medical information and that my SMPP username and password should not be shared with another person.
- ____ I understand that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- ____ I understand that SMPP contains selected, limited medical information from my medical record and that SMPP does not reflect the complete contents of my medical record. I also understand that a paper copy of my complete medical record may be requested from DFD Russell Medical Centers.
- ____ I understand that my activities within SMPP may be tracked by computer audit and entries I make may become part of the medical record.
- ____ I understand that access to SMPP is provided by DFD Russell Medical Centers as a convenience to its patients and that DFD Russell Medical Centers has the right to deactivate access to SMPP at any time for any reason. I understand that use of SMPP is voluntary and I am not required to use SMPP.
- ____ I understand that a full copy of the SMPP Terms and Conditions are available for review online.
- ____ I understand that messages to be sent using SMPP are to be of a **non-urgent** nature.
- ____ By signing below, I acknowledge that I have read and understand this SMPP Access Form and agree to all terms.

Patient's Signature / Authorized Person: _____

Date: _____

For Office Use Only

Photo ID verification: Yes No

Staff Initials: _____