Wray Hospital & Clinic

Patient Authorization to Access Portal

I request electronic access to **my** health information at Wray Community District Hospital and Clinic. As a patient, I acknowledge and agree to the following:

- I consent to participation in Wray Community District Hospital and Clinic (WCDH) Patient Portal and understand that my personal, identifiable health information will be made available to me electronically thru that Portal.
- I understand that the use of the Portal is voluntary and intended for **non-emergent purposes only.**
- I understand that I will have the ability to view, download, and transmit my individual health information.
- I understand that my health record may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; I authorize access to such information.
- I release WCDH, its employees and agents, medical staff, and business associates from legal responsibility or liability for my re-disclosure of Portal information to the extent indicated and authorized herein.
- I understand that there are risks associated with web-based applications and that I am responsible for safeguarding my access.
- I understand it is my responsibility to protect my username and password. I will not hold WCDH liable if I lose or share this information.
- I will receive an e-mail invitation to activate my access. I understand once I receive the invitation, if I don't log in within 90-days, I will need to complete a new request.
- I may refuse to sign this authorization form. WCDH will not condition or deny treatment on my signing this authorization.
- I understand that my email address is required to initiate Portal access. If my e-mail address changes, I will contact WCDH at 970-332-2214.
- If I choose to terminate Portal access, I will contact WCHD at 970-332-2214.

Email Address: _____

Patient Name_____ Date of Birth_____

_____ _____

Patient/Legal Representative Signature Relationship to Patient/Authority