WMC Health | HealthAlliance
Westchester Medical Center Health Network

PATIENT PORTAL
Terms of Use

PLEASE PRINT CLEARLY

Patient Name _____
Last Name **First** **Middle**

Date of Birth _____
Month / Day / Year

Contact Phone Number: (_____) _____ - _____

Mailing Address: _____

_____

_____

Purpose of this Form /Terms of Use

HealthAlliance of the Hudson Valley ("HealthAlliance") offers free secure access to our Hospitals' patients who wish to view parts of their medical records using our Patient Portal. Accessing your health Information through a secure Patient Portal can be a valuable tool, but can also involve certain risks. In order to manage these risks, we need to impose some conditions of participation that you will need to accept and agree to before receiving access to the HealthAlliance Patient Portal.

How the Secure Patient Portal Works

The Portal is a secure web page that uses encryption and other security measures to keep unauthorized persons from reading information. Secure patient Information can only be accessed by someone who knows the correct user name and password to login, as well as the correct answers to the security questions you select. You will receive an invite to register to the HealthAlliance Patient Portal through an E-Mail address you provide at the time of registration. HealthAlliance utilizes RelayHealth (a division of McKesson) to securely and conveniently maintain our patient portal.

How to Participate in our Patient Portal

You must be 13 years of age or older to be able to participate in our Patient Portal.

Once the appropriate Consent Forms are agreed to and signed, you will receive an E-Mail invitation to our Patient Portal upon discharge from the Hospital.

Depending upon which HealthAlliance hospital you were a patient at, an E-Mall will be sent from one of the following:

HealthAlliance.Broadway@Direct.RelayHealth.com
HealthAlliance.MarysAve@Direct.RelayHealth.com
HealthAlliance.Margaretville@Direct.RelayHealth.com

Within this E-Mail invitation, you will be provided a specific website link (Internet address) to our Portal for you to easily register. Please refer to our Patient Portal brochure provided to you at time of registration to help guide you through this process.

Medical Advice and Information Disclaimer

DO NOT use this Patient Portal to communicate a medical emergency or urgent health issue.
Call 911 if you need immediate help with a medical emergency.

Nothing in the Patient Portal is intended to be used for the purpose of medical diagnosis or treatment. The information posted by HealthAlliance on this Patient Portal should not be considered complete, nor should it be relied on to suggest a course of treatment for a particular individual. You should always seek the advice of your primary care physician or health care provider with any questions you may have regarding a medical condition and you should never disregard medical advice or delay in seeking it because of something you may read on this Patient Portal.

If you add information to your personal health record through this Patient Portal, HealthAlliance Hospital staff may not be able to access your new information at future Hospital visits.

Protecting Your Private Health Information and Risks

This method of viewing prevents unauthorized parties from being able to access or read information while they are in transmission; however, keeping information secure depends upon two additional factors: the secure information must reach the correct E-Mail address and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present.

Be sure HealthAlliance always has your current, correct E-Mail address and is promptly informed if it ever changes. You also need to keep track of who has access to your E-mail account so that only you, or someone you authorize, can see the messages you receive from us.

You are solely responsible for protecting your password. If someone obtains your password, he or she will be able to access all of your personal health information. If you think someone has learned your password, you should promptly go to the Patient Portal website and change it. If you believe that there has been unauthorized access to your patient portal, contact RelayHealth Customer Support at 1-866-735-2963.

Conditions of Participating in the Patient Portal

You agree to use the Patient Portal only for lawful purposes. Access to this secure web portal is an optional free service, and we may suspend or terminate your access at any time and for any reason. If we do suspend or terminate this service, you will be notified as promptly as we reasonably can. You agree to not hold HealthAlliance[1] or any of its staff liable for network infractions beyond its control.

Liability/Indemnification

HealthAlliance[1] does not assume any liability for the materials, information and opinions provided on, or available through, the Patient Portal (the "Site Content"). Reliance on the Site Content is solely at your own risk. HealthAlliance[1] disclaims any liability for injury or damages resulting from the use of any Site Content. You agree to indemnify and hold harmless HealthAlliance[1] and its officers, directors, employees, agents, affiliates, third party information providers, licensors, and others involved in the Patient Portal from and against any and all liabilities, expenses, damages, and costs, including reasonable attorneys' fees, arising from any violation by you of these Terms of Use or your use of the Patient Portal or any products, services, or information obtained from this Patient Portal.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

By signing below, I acknowledge that I received the HealthAlliance[1] **Patient Portal Terms of Use**, and that I understand and agree to abide by all the provisions of the Patient Portal Terms of Use as they may be modified from time to time. I understand the risks associated with using the Patient Portal, including compromise of protected health information resulting from an encrypted E-Mail being delivered to the wrong address because I did not update the Patient Portal with my new E-Mail address. I understand that my Patient Portal account access may be terminated and disabled if I fail to follow the Patient Portal Terms of Use.

_____ _____/_____/_____ _____ **AM / PM**

Signature of Patient (13 years of age or older) ***Date*** ***Time***

IF APPLICABLE:

_____ _____

Print Name of Legal Representative **Relationship to Patient**

_____ _____

Signature of Legal Representative **Date**

[1] *HealthAlliance of the Hudson* Valley (HealthAlliance) is an integrated, multi-campus health care system that consists of Mary's Ave Campus (formerly Benedictine Hospital), Broadway Campus (formerly The Kingston Hospital), and Margaretville Hospital.

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PATIENT PORTAL
Authorization for Release of Protected Health Information

Our priority is always you, and ***HealthAlliance of the Hudson Valley*** understands the importance of privacy in regard to your health care and continually strives to make your information as confidential as possible.

PATIENT PORTAL STATUS

NOTE: Patient must be 13 years of age or older to register for the patient portal.

☐ **YES, Please generate an E-Mail invitation so I can register for the Hospital's Patient Portal.**

The E-Mail address to use to send my invitation to is: (PLEASE PRINT CLEARLY)

_____ @ _____ . _____

I understand that by answering "yes" above, a link will be sent to this E-Mail address that will allow the recipient to access my personal health record that contains health, financial and demographic information about me. I understand that if I am providing an E-Mail address that belongs to another person or an E-Mail address that can be accessed by another person(s), such person(s) may have access to my personal health record.

In accordance with applicable law, I understand that:

- If applicable, this authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-RELATED INFORMATION
- I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

I have read the foregoing and authorize **HealthAlliance**[1] to send to the E-Mail listed above a link to my personal health record. All items on this form have been completed and my questions about this Form have been answered. In addition, I have been provided a copy of the Form.

_____ _____
Signature of Patient or Representative authorized by law ***Relationship if other than patient***

Date: _____/_____/_____ **Time:** _____ **AM / PM**

NOTE: If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

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