

PATIENT SORTAL

IS YOUR RELEASE DAY COMING UP?

Get the healthcare you deserve when you sign up with Patient Sortal today.



WHAT TO EXPECT FOR THE FIRST 30 DAYS:

3 days

Contacted by a Patient Sortal team member from 1-833-728-1368 on the number provided.

7 days

Care management intake (30–60 min).

14 days

Appointment with your healthcare provider and labs ordered (60 min) – bring medication names, questions, concerns, etc.

After 2 weeks

Review labs and build a care plan during your second appointment.

3 weeks +

Our receptionist reaches out to schedule next appointment according to the care plan.

**PATIENT SORTAL
NEW MEMBER ENROLLMENT FORM**

(Please fill out all blanks and submit completed form to your counselor or a reentry staff member)

First Name: _____ **Last Name:** _____

DOC Number: _____ **Date of Birth:** _____

State Located (ex. PA): _____ **Facility Name:** _____

Incarceration Date: _____ **Projected Release Date:** _____

Are you?: Max out Paroling Trying to Parole

Circle of Care: Please provide at least one family member, friend, or emergency contact we can reach if we lose contact with you post release to make sure you are connected with your care team.

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

How did you hear about us? _____

Any additional questions at this time: _____

Member Emergency Contact:

Emergency Contact Name _____

Emergency Contact Number _____

Emergency Contact Email _____

Emergency Contact Address _____

I consent to Patient Sortal calling, texting, or mailing enrollment information. _____
Initials

Signature

Date

THANK YOU FOR BECOMING A MEMBER OF PATIENT SORTAL

We are excited to work with you!

**PATIENT SORTAL
HIPAA RIGHT OF ACCESS**

(PATIENT SORTAL MEMBERS SHALL COMPLETE, CHECK, AND SIGN ALL BOXES THAT APPLY)

Pursuant of 45 CFR § 164.524, HIPAA Authority for Right of Access, the undersigned request the _____ to release or disclose information related to below reference records/information to Patient Sortal during the period **beginning** (incarceration date) _____ and **ending** (30 days prior to release date) _____, for assistance with Continuity of Care during Community Reintegration. According to the Office of Civil Rights, an individual (or that individual's personal representative) has a right to direct a covered entity to transmit Protected Health Information (PHI) about the individual directly to another person or entity designated by the individual (or personal representative) pursuant to the right of access granted under HIPAA and its implementing regulations.

Patient Information:

Name (print):	Inmate #:	Date of Birth:	Facility Located:
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Check all records that apply:

Medical/Dental ___ Mental Health ___ Drug & Alcohol Treatment ___ HIV Information ___
Current Medication Reconciliation Record ___ Labs (last 6 months) ___ Problem List ___

Records/Information to be delivered to:

Patient Sortal

Email (preferred): 4851-8650-9813@mail.vault.netdocuments.com

Phone: 1-833-PATIENT or 1-833-728-1368

Fax: 844-927-5012

Name of Individual Giving this Authorization (print)

Relationship (print)

Signature of the individual Giving this Authorization

Date

Signature of Witness

Date