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PATIENT PORTAL INFORMED CONSENT

Patient Information:

NAME_____**DOB**_____

ADDRESS_____

EMAIL ADDRESS_____

****OPTIONAL: Allow Portal Access to My Health Information to the Following Individual:**

NAME_____**DOB**_____

Relationship to Patient:_____

ADDRESS_____

EMAIL ADDRESS_____

Permissions to: (You must write "Yes" or "No" to specify level of access requested)

Appointments:	**View Only**_____	**or Full Access**_____
Health Information:	**View Only**_____	**or Full Access**_____
Medication Requests:	**View Only**_____	**or Full Access**_____
Secure Messaging:	**View Only**_____	**or Full Access**_____

PATIENT CONSENT:

PATIENT NAME_____

PATIENT SIGNATURE_____

DATE:_____