PORTAL REGISTRATION AND CONSENT FORM

I understand that this agreement will remain in effect for 12 months. At the end of that time, I may be asked to renew my confidential email account and Patient Portal Login. It is my responsibility to notify our practice if there is a change in my email account or I feel that my secure password has been breached.

Please Print Clearly

Full Name _____ Date of Birth _____

Address _____

City _____ State _____Zip Code _____

Confidential e-mail address

Confirm e-mail address

Signature _____

Date _____

You may request a copy of the Policy and Procedures
If you choose to view it online, your signature on this form is your agreement to the Policy and Procedures for our Patient Portal.

*Some features of the Patient Portal may not be available to all patients.