PATIENT PORTAL APPLICATION

INFORMED CONSENT
& USER AGREEMENT FORM

Patient Information

Name: _____ DOB: _____

Address: _____

E-mail Address: _____

OPTIONAL: Allow Others to Access Your Health Information

You can allow Portal Access to your health information by completing the portion below with that person's information. A form is needed for each person you want to give access.

Name: _____ DOB: _____

Relationship to Patient: _____

Address: _____

E-mail Address: _____

Permissions for Added Person - You must write "Yes" or "No" to specify the level of access you are requesting.

"View only" gives permission only to view that information, not to make requests or send communication.

"Full access" gives permissions to send and receive all communications.

- 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 and Agreement:

Patient Name: _____

Patient Signature: _____

Date: _____

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THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

COLUMBUS
PUBLIC HEALTH