PATIENT PORTAL USER CONSENT

Patient Name: _____ Date of Birth: _____

Patient Email: _____ Telephone: _____

By signing this Patient Portal User Consent, I (the above named Patient) hereby agree as follows:

- I authorize the Boca Grande Health Clinic, Inc., to communicate with me, and I may communicate with the Clinic, via its personal, secured access Patient Portal concerning my medical care and treatment.
- I understand that I should not use the Patient Portal for medical emergencies. If I have a medical emergency I understand that I should call 911 and/or seek care at a hospital emergency room.
- I understand that the Patient Portal is not to be used for "Online Doctor Visits" and/or other unintended purposes addressed in the Portal Terms of Use.
- I acknowledge that I have received the Boca Grande Health Clinic, Inc., Patient Portal Terms of Use and have read and understand and agree to abide by those terms.
- I acknowledge that it is my responsibility to safeguard my User password and/or any information received by me via the Patient Portal.
- I understand that I have the right to revoke this Consent at any time. If I want to revoke this Consent, I must do so in writing, and address it to the Boca Grande Health Clinic, Inc., P.O. Box 517, Boca Grande, Florida 33921. I understand that I may also hand-deliver my written revocation of this Consent.
- I also understand that if I choose to revoke this Consent, Boca Grande Health Clinic, Inc., will not deny or refuse to provide me any of its medical or administrative services normally provided to non-Patient Portal Users or limit in any way my patient rights.
- Furthermore, I understand that Boca Grande Health Clinic, Inc. may in its sole discretion, add to, modify or discontinue any or all of the services provided through its Patient Portal.

I hereby request access to the Boca Grande Health Clinic, Inc. Patient Portal for the above named Patient.

Signature _____ Date: _____

If the person signing this form is other than the above named Patient, please indicate the capacity in which you are requesting access to the Boca Grande Health Clinic, Inc. Patient Portal. I am the above named Patient's: Legal Guardian; _____Parent, if a Minor; _____ (If Other, Please Describe): _____

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