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PATIENT PORTAL AUTHORIZATION FORM

Patient Name:

DOB:

Patient Name:

DOB:

Patient Name:

DOB:

Patient Name:

DOB:

Parent or Legal Guardian:

Personal Email Address:

Note: This authorization is deemed invalid unless all fields are completed:

Others:

Signature of Patient or Legal Representative:

Printed Name of Patient or Representative:

Relationship to Patient or Authority to Act for Patient:

Date:
