WHITSETT VISION GROUP

Patient Portal Additional Access Form

Additional User Access Only

Patient Name (please print): _____ Patient DOB: _____

Patient Email Address: _____

I authorize the below named individual to be given full access to my Patient Portal Account. I understand this means they can communicate to the office on my behalf and may see parts of my medical record (PHI). I understand I can remove this access at any time via the patient portal or by calling my provider's office.

Additional User Name (please print): _____ Patient DOB: _____

Additional User Email Address: _____

Patient Signature: _____ Date: _____

Legal Guardian (please print): _____

Legal Guardian Signature: _____ Date: _____

Dependent Access Only (for parents of children under 18 years of age)

Dependent's Name (please print): _ Dependent's DOB: _

Dependent's Email address: _

Legal Guardian Email Address: _____

Legal Guardian Signature: _____ Date: _____

Parents will receive full access to their dependent's Patient Portal Accounts

Please ensure this form is signed and dated. Forms received that are not signed and dated will not be processed.

WHITSETT VISION GROUP
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