

PATIENT CONSENT FORM

Patient access to the **Med Path Clinic** Patient Portal is granted by signing and acknowledging the Terms of Use prior to accessing the service online.

I, _____, request access to the **Med Path Clinic** Patient Portal.

I have read the **Med Path Clinic** Patient Portal Terms of Use Agreement and other information provided to me regarding the **Med Path Clinic** Patient Portal. I have been given the opportunity to ask questions about the service and acknowledge that I understand the following:

- ✓ My use of this service is voluntary and I may withdraw from using this service at any time, which will not affect my patient status at any **Med Path Clinic**.
- ✓ Other than for the purposes of administration of this service by the authorized personnel of **Med Path Clinic**, its affiliates and franchises, no other person will have access to my personal health information through the **Med Path Clinic** Patient Portal, except as permitted with my written consent.
- ✓ Clinical health information available through the **Med Path Clinic** Patient Portal is provided by **Med Path Clinic** at my request for my personal use only and may be subject to verification without notice.
- ✓ **Med Path Clinic**, its affiliates, and franchises assume no liability for the release of clinical health information to me and my use of it.
- ✓ Access to and use of the **Med Path Clinic** Patient Portal is subject to the **Med Path Clinic** Patient Portal Terms of Use and Agreement for this service, and I agree to be bound by the aforementioned agreement.
- ✓ I will receive a copy of this signed form.

Name of Patient (First, Last) [PRINT]

Signature

Date

Name of Witness (First, Last) [PRINT]

Signature

Date

Patient Address

Daytime Phone number

E-Mail Address [PRINT]*

Health Card Number

Date of birth