Patient Portal Consent Form

By signing below, I authorize Wilson Family Medicine to send an email regarding the patient portal information to the below email. Additionally, I give my expressed consent for my medical information to be made available using Patient Shift. I understand I have the right to obtain a copy of this consent upon completion. This consent must be given by the patient unless the patient is under 12 years old or Representative has guardianship of incapacitated or disabled persons.

Patient Name: _____
First Name Middle Initial Last Name Date of Birth

Address: _____
Street City State Zip Code

Email address that is authorized to receive the Account Link email: ☐

☐ Check this box this email address belongs to the patient

If the email address does not belong to the patient, please complete the following:

Representative: _____
First Name Middle Initial Last Name

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Representative ☐ Surrogate

I understand that my medical information is protected by both federal and state law. This consent may give the requesting user access to sensitive information related to the testing, diagnosis, or treatment for conditions including, but not limited to, HIV/AIDS or other communicable diseases, drug and alcohol abuse; mental, psychotherapy, or other behavioral health; genetic testing; or any condition expressly protected by Florida Law. This consent will remain in effect unless I deactivate my account or provide written notice to the healthcare organization. If I am removed as a user from the account, I will no longer have access to the medical information communicated between the practice and patient aforementioned.

I understand that my login credentials are unique to me and will not share this information with another individual. If I share this information I further understand that health information disclosed may not be protected under federal or state law as it could be released by the individual gaining access.

☐ I do wish for the healthcare organization to make my medical information available through Patient Shift for the aforementioned individual.

Patient/Representative Signature:

_____
Signature

_____
Print Name Date

_____
Relationship to Patient*

Wilson Family Medicine Witness Signature:

_____
Signature

_____
Print Name Date

* Legal authority must be verified when an individual is signing on behalf of the patient.