



Adult & Adult Proxy Authorization Form

**** Adult & Adult Proxy Access to Patient Portal account is for adults 18 years of age or older****

PATIENT'S INFORMATION

All fields are required

Patient's Name: _____ Last 4 digits of SS#: _____ DOB: _____

Address: _____ Primary Care Physician: _____

City, State, Zip: _____ Primary Phone Number: _____

Would you like access to the Patient Portal?

- YES
- NO – I decline access to the patient portal at this time

If "yes", please provide an email address unique to you: _____

I have read and understand the Patient Portal Disclosure to me by Sebastopol Orthopaedics & Sports Medicine regarding my Patient Portal account and my responsibility in safe guarding my health information. By signing I agree to only use the patient portal for non-urgent communication and will call the office for all urgent issues.

Date: _____ Patient Signature: _____

PROXY'S INFORMATION

All fields are required

Proxy's Name: _____ DOB: _____

Address: _____ Relationship: _____

City, State, Zip: _____ Primary Phone Number: _____

I grant access to the Patient Portal to the above listed person?

- YES
- NO – revoke access to my patient portal to the above listed person

If "yes", please provide an email address unique to proxy: _____

I have read and understand the Patient Portal Disclosure & Patient Portal Adult Proxy Access documents provided to me by Sebastopol Orthopaedics & Sports Medicine regarding the Patient Portal account and my responsibility in safe guarding health information. By signing I agree to only use the patient portal for non-urgent communication and will call the office for all urgent issues.

Date: _____ Patient Signature: _____