



PRIMARY CARE PARTNERS

Patient Portal Signup Sheet

Name of individual requesting account: _____

Select Relationship: Self
 Spouse
 Parent
 Legal Guardian
 Other (Please describe): _____

Requestor's Home Address: _____

Requestor's Phone Number: _____

Requestor's Date of Birth: _____

Requestor's Email Address: _____

Please Select a User Name: _____
(Case Sensitive – At Least 5 Characters – Letters and Numbers Only)

Please list the name of the individual whose medical record you are requesting access to.
(A proxy authorization form may need to be completed)

Name: _____ DOB: _____

Name: _____ DOB: _____