

Re: \_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
(Date of Birth)

Account Number:

### *PATIENT PORTAL ACTIVATION*

Our office now has the ability to communicate with patients through an electronic Patient Portal. This portal will allow you to request appointments, view lab results, view current scheduled appointments, request medication refills, request referrals to specialists, complete medical questionnaires, view summaries of your recent visits and more. In order to activate this functionality for you personally, we MUST have an active e-mail address associated with your account.

Please list your e-mail address here: \_\_\_\_\_ @ \_\_\_\_\_

We will activate your account within 48-hours and you will receive an e-mail within 48 hours with your login information to setup your private account.

### *AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY*

I authorize this office to have access to my prescription drug history. I understand this authorization allows this office to obtain my prescription history electronically from retail pharmacies.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

### *AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION*

Federal privacy guidelines, HIPAA, prevent this office from disclosing protected health (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize Dallas Center for Pelvic Medicine to disclose PHI from my medical or financial record to the following person/people:

1. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Type of Information: (Check One)  Medical  Financial  Both

2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Type of Information: (Check One)  Medical  Financial  Both

