Meetinghouse Family Physicians

PATIENT PORTAL AUTHORIZATION

Date: _____

I authorize Meetinghouse Family Physicians to send secure emails regarding my Personal Health Information to my secure log-in on STI's Patient Portal.

Email: _____
(Please print clearly as this must be entered accurately into our system.)

Name: _____
(Please print.)

Signature: _____

I also authorize the use of the patient portal for the dependant children listed below:

_____

_____

_____

_____

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