

**PATIENT INFORMATION:**

Last Name		First Name		Middle Initial
Date of Birth	Email Address		Re-enter Email Address	
Street Address		City	State	Zip Code
Primary Phone Number		Secondary Phone Number		

By signing below, I authorize Palomar Health to send an email invitation to the email address above. This invitation will allow me to sign up for and access the MyPalomarHealth patient portal. This portal may contain information regarding:

- Selected portions of my medical information such as allergies, immunizations, and problem lists
- Various Appointment reminders
- Selected lab results
- Other functionalities, as these are added to the MyPalomarHealth Portal

Further, I understand I must log-in to MyPalomarHealth using my own unique user ID and Password, and that I am responsible for keeping my user ID and Password confidential. I agree to abide by the Terms and Conditions of Use of the MyPalomarHealth site. MyPalomarHealth is not to be used in emergency situations. If I have a medical emergency or an urgent medical question, I will call 911 or contact my health care provider directly.

I understand and acknowledge that information regarding my treatment, physical, mental condition, drug/ alcohol abuse, and/or HIV/AIDS diagnoses may be included in the MyPalomarHealth Portal.

Signature of Patient: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

Pt Name  
MR #  
Date \_\_\_\_\_ Age \_\_\_\_\_  
Sex:  M  F  
Affix pt name label here

N8700-793 (1/2/14)

**PATIENT PORTAL CONSENT FORM**



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