

**Patient Portal Request Form (Adult)**  
(Form A)

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**Access to a Patient Portal**

To sign up for access to a patient’s portal, please complete this Form. You will need to submit a government issued ID for verification when completing.

**A. Patient’s Information** (To Be completed by the patient requesting access. All Sections required. Please Print Clearly.)

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M / F  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Last 4 of SSN: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Phone Type: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**B. Patient Portal Terms and Agreement**

- I understand that the Patient Portal is intended as a secure online source of confidential medical information. If I share my Patient Portal ID and Password with another person, that person may be able to view my health information.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner and to change my password if I believe it may have been compromised in any way.
- I understand that access to the Patient Portal is provided by Ascension as a convenience to its patients and that Ascension has the right to deactivate access to the Patient Portal at any time for any reason. I understand that use of the Patient Portal is voluntary, and I am not required to use the Patient Portal.
- By signing below, I acknowledge that I have read and understand this Patient Portal form and the Ascension Terms and Conditions, and attest that I am the above-named patient.

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

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

