Intercoastal **Medical Group**
INCORPORATED

PORTAL CONSENT FORM

I authorize the following individual to be granted patient portal access to my Intercoastal Medical Group account only. It is my responsibility to notify Intercoastal Medical Group of any changes, including removing access of any individual listed below. I do not hold any employee and/or provider liable if I fail to notify Intercoastal Medical Group of such changes. I understand that this access form is for ALL providers of Intercoastal Medical Group, Inc.

____

Please Print Patient (Last Name) (First Name) (M.I.) (DOB)

Grant Access To:

Name: ____ DOB: ____________

Address: ____ ZIP: ____________

Email address: ____

Relationship to patient: ____

I release and hold harmless Intercoastal Medical Group, INC. and the physician's medical practice, members and employees, for all liability, including negligence, which may arise from complying with this authorization. I understand that Intercoastal Medical Group, Inc. cannot guarantee that the recipient will not use or disclose my information. I have the right to revoke this authorization at any time, and Intercoastal Medical will cease all access.

____

Signature of Patient or Guardian Date