E-PORTAL ACTIVATION REQUEST

I HEREBY AUTHORIZE FASTER CARE TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI) VIA SECURE WEB PORTAL.

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH: _____

SSN: _____

ADDRESS: _____

E-MAIL ADDRESS TO BE PORTAL ENABLED: _____

SIGNATURE: _____ DATE: _____

ONCE YOU ARE WEB-ENABLED YOU WILL RECEIVE AN E-MAIL WITH INSTRUCTIONS TO ACTIVATE THE PORTAL.