Portal Authorization Form

Name:_________________________________ **Date of birth:**_____________ **Date completed:**____________

By signing this document I agree to use the patient portal to access my own records. I understand that I have a responsibility to protect my own log in and password information, and that AVP Primary care, PLLC will not be held liable for breeches of confidentially arising from unauthorized use of such information. If I become aware of a breech of the confidentiality, I will report it to AVP Primary Care, PLLC immediately.

I acknowledge that this portal is intended as a convenient service, and not a replacement for in-person healthcare. I understand that it is inappropriate and dangerous to use this portal for emergency diagnosis or treatment. For non-emergent issues, if I do not receive a response within 24 hours, I agree to contact AVP Primary Care, PLLC by conventional means, such as by phone or in person.

A Portal account was created and I was provided with Portal Activation letter, including the URL (Internet address) for the Patient Portal, user name and password, which I will use to log in to the Portal.

Please sign and date below:

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Signature of Patient / Legal Guardian Date