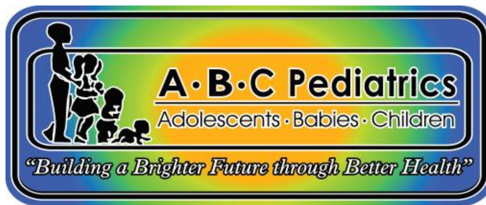

Patient Portal Invite Request Form

Please print

Hello! To receive access to your child(ren)'s patient portal account, please complete:

Patient Name:	First / Middle / Last	Patient's Date of Birth: / /
Patient Name:	First / Middle / Last	Patient's Date of Birth: / /
Patient Name:	First / Middle / Last	Patient's Date of Birth: / /
Patient Name:	First / Middle / Last	Patient's Date of Birth: / /
Patient Name:	First / Middle / Last	Patient's Date of Birth: / /

EMAIL address	

Your signature below certifies legal guardianship of the above listed child(ren).
Your signature below certifies the email listed above belongs to you.

____

Signature of Guardian

____

Printed Name

____

Relationship to patient(s)

____

Date