Uptown Pediatrics, PC

Parent/Guardian/Patient Request to Access Patient Portal

Please Print Clearly

*****Form Must Be Provided To The Office Staff In Person. Faxed, emailed or mailed reciept of this form is not acceptable*****

Parent Name: _____

(Patient Name if over 18yrs)

Parent Email: _____

(Patient Email if over 18yrs) ***Can we keep this email address on file for other communication such as practice updates and important reminder?***

__ Yes __ No

Parent Phone: _____

(Patient Phone if over 18yrs)

*****For Population Health Reporting Selection required:***

Race:

__ American Indian or Alaska Native
__ Asian
__ Black or African American
__ Native Hawaiian or Other Pacific Islander
__ Caucasion
__ Other _____
__ Prefer not to answer

Ethnicity:

__ Hispanic or Latino
__ Not Hispanic or Latino
__Other _____
__ Prefer not to answer

Patients requested for portal access

First Name	Last Name	Birth Date

Authorized Signature _____

Must be authorized parent, legal guardian or the patient. By signing this form, I certify that I am the authorized person to access data within the patient portal

Please allow 72 hours to receive your email from our office containing your tempory password to access the portal.

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