BROWARD HEALTH

PATIENT PORTAL CONSENT FORM

By signing below, I authorize Broward Health to send email communications regarding the patient portal to the email address identified below and give my expressed consent for my medical information to be made available to me using *myBrowardHealth*. I understand that I have the right to receive a completed copy of this consent.

Patient Name:

Last Name	Middle	First Name	Date of Birth

Address:

Street	City	State	Zip

Please clearly print or type the email address authorized to receive the email invitation:

Please clearly re-print or re-type the email address authorized to receive the email invitation:

Complete the following if the email address does not belong to the patient:

Recipient:

Last Name	Middle Initial	First Name

Relationship to the Patient

I understand that my health information is protected by federal and state law. This consent applies to records which may contain information related to the testing, diagnosis or treatment for conditions including, but not limit to, drug and alcohol abuse; psychotherapy, mental or other behavioral health; HIV/AIDS or other communicable diseases; genetic testing; or any other condition expressly protected by Florida Law. This consent will remain in effect unless I deactivate my account or written notice is provided to Broward Health.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment, payment for my treatment, enrollment in a health plan, or eligibility for benefits. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

☐ **YES** I do wish to access my medical information and give my expressed consent for Broward Health to make my medical information available to me using *myBrowardHealth*

Patient or Representative Signature:

Signature

Print Name Date

Relationship to Patient*

**Legal authority must be verified when an individual is signing on behalf of the patient.*

Broward Health Witness Signature:

Signature

Print Name Date