PREMIER PHYSICIANS

AUTHORIZATION FOR ACCESS TO PATIENT PORTAL

With the new Premier patient portal, you will be able to access your medical information online. In order for you to register, we need the following information:

Patient Name: ______________________________

Date of Birth: ______/______/______

Street Address: ______________________________

City: ______________ ***State:*** __________ ***Zip:*** __________

Email address (please print):

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☐ I authorize Premier Physicians to initiate the process for access to my online patient portal for medical information. I understand that I will receive an email with my one time sign on, password and instructions to the email address provided. I understand that Premier Physicians staff will not have access to my portal email account. The information provided by me is given freely and is not conditioned on any past or future payment.

Print Name: ______________________ ____/______/____
Date Signed

Signature of Patient/Legal Representative: ______________________

Relationship If Not Patient: ______________________________