



allergy  
asthma  
immunology

## PRACTICE PORTAL

Possible actions include:

- secured electronic communications, including attachments
- make requests for appointments
- make prescription refill requests
- change your address, insurance information, etc
- access to your health records
- ask billing questions
- pay bills online

If you would like access, please complete the following:

PATIENT NAME:

PATIENT DATE OF BIRTH:

PATIENT ZIP CODE:

PATIENT E-MAIL:

IS THIS THE PATIENT'S PERSONAL E-MAIL?    YES                    NO

**Please note that ALL of the above information is required to sign onto the portal.**

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If the patient is a minor or if there is someone else that you would like to have access (optional), please provide the following information. **Please note that this person would have FULL ACCESS to your information.** There is no capability to provide partial access.

PERSON'S NAME:

PERSON'S DATE OF BIRTH:

PERSON'S ZIP CODE:

PERSON'S E-MAIL:

RELATION TO PATIENT:

**Please note that ALL of the above information is required to sign onto the portal.**

\_\_\_\_\_  
PATIENT/LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

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**PLEASE NOTE THAT E-MAIL INVITES ARE VALID FOR ONLY 48 HOURS. PLEASE CHECK JUNK MAIL AND SPAM BOXES FOR THE INVITE. IF THE INVITE HAS EXPIRED, PLEASE CALL THE OFFICE FOR ANOTHER INVITATION.**