PATIENT PORTAL CONSENT FORM

PATIENT'S NAME _____ DOB _____

ACCEPT

I _____ **AGREE** to the terms of accessing my child's patient portal through Madison Pediatrics. I understand that Madison Pediatrics will email me a link that will provide access to my child's medical records under the circumstances that I have to create the account myself.

EMAIL _____

_____ _____

➜ ☆ **Signature of Parent / Legal Guardian** **Date**

DECLINE

I _____ have received all the information necessary to gain access to my child's patient portal, but at this time **I DECLINE**. I understand that if at any time I wish to gain access, all I have to do is ask and the information will be sent to me electronically to gain access.

_____ _____

➜ ☆ **Signature of Parent / Legal Guardian** **Date**

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