PATIENT CONSENT FORM

Patient access to the WELLVIEW MEDICAL INC. Patient Portal is granted by signing and acknowledging the Terms of Use prior to accessing the service online.

I, _____, request access to the WELLVIEW MEDICAL INC. Patient Portal.

I have read the WELLVIEW MEDICAL INC. Patient Portal Terms of Use Agreement and other information provided to me regarding the WELLVIEW MEDICAL INC. Patient Portal. I have been given the opportunity to ask questions about the service and acknowledge that I understand the following:

- ✓ My use of this service is voluntary and I may withdraw from using this service at any time, which will not affect my patient status at any WELLVIEW MEDICAL INC.
- ✓ Other than for the purposes of administration of this service by the authorized personnel of WELLVIEW MEDICAL INC. its affiliates and franchises, no other person will have access to my personal health information through the WELLVIEW MEDICAL INC. Patient Portal, except as permitted with my written consent.
- ✓ Clinical health information available through the WELLVIEW MEDICAL INC. Patient Portal is provided by WELLVIEW MEDICAL INC. at my request for my personal use only and may be subject to verification without notice.
- ✓ WELLVIEW MEDICAL INC., its affiliates, and franchises assume no liability for the release of clinical health information to me and my use of it.
- ✓ Access to and use of the WELLVIEW MEDICAL INC. Patient Portal is subject to the WELLVIEW MEDICAL INC. Patient Portal Terms of Use and Agreement for this service, and I agree to be bound by the aforementioned agreement.
- ✓ I will receive a copy of this signed form.

_____	_____	_____
Name of Patient (First, Last) [PRINT]	Signature	Date
_____	_____	_____
Name of Witness (First, Last) [PRINT]	Signature	Date
_____		_____
Patient Address		Daytime Phone number
_____	_____	_____
E-Mail Address [PRINT]*	Health Card Number	Date of birth