



**CORVALLIS
FAMILY MEDICINE** P.C.
Your family's health begins here.

2400 NW Kings Blvd.
Corvallis, Oregon 97330
Phone: 541-757-2400

Patient Portal Agreement

I authorize Corvallis Family Medicine to upload my health records to a secure online Patient Portal and communicate with me through electronic communication. I understand that should there be a health risk, a phone call or visit will be needed. I understand that I have the right to terminate my Patient Portal account at any time, withdrawing access to the account. Withdrawal from this agreement must be done by written request to Corvallis Family. In the event that I no longer receive care from Corvallis Family Medicine, I understand my Portal account will be inactivated.

If this form is not submitted in person, a copy of state-issued identification (front and back) must be included. A phone call will be made with credentials once the account is created.

Patient Name: _____
 Patient Date of Birth: _____
 Patient Account #: _____

 Individual email address (unshared)

 Signature

 Date

 Signers authority (if not patient)

Office Use Only

CFM Witness _____