[] **[WEXFORD MEDICAL] <1 WEXFORD RD BRAMPTON ON>**

PATIENT CONSENT FORM

Patient access to the [**WEXFORD MEDICAL**]> Patient Portal is granted by signing and acknowledging the Terms of Use prior to accessing the service online.

I, _____ , request access to the [**WEXFORD MEDICAL**]> Patient Portal.

I have read the [**WEXFORD MEDICAL**]> Patient Portal Terms of Use Agreement and other information provided to me regarding the [**WEXFORD MEDICAL**]> 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 [**WEXFORD MEDICAL**]>.
- ✓ My use of this service will be kept confidential by [**WEXFORD MEDICAL**]> and any disclosures of my personal health information through this service will be made only with my expressed consent.
- ✓ Other than for the purposes of administration of this service by the authorized personnel of [**WEXFORD MEDICAL**]>, its affiliates and franchises, no other person will have access to my personal health information through the [**WEXFORD MEDICAL**]> Patient Portal, except as permitted with my written consent.
- ✓ Clinical health information available through the [**WEXFORD MEDICAL**]> Patient Portal is provided by [**WEXFORD MEDICAL**]> at my request for my personal use only and may be subject to verification without notice.
- ✓ [**WEXFORD MEDICAL**]>, 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 [**WEXFORD MEDICAL**]> Patient Portal is subject to the [**WEXFORD MEDICAL**]> 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