User Electronic Mail Authorization Form for Patient Portal

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus within 3-5 business days after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

You will receive a copy of this form with your Medical Record Number ("MRN"). **Your MRN will be necessary to complete your enrollment with My Care Plus Online.**

If you wish to discontinue utilizing the Portal, please contact our office at (707) 551-3300 or email info@solanohemonc.com.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form.

________________________________ Name of Authorized User

________________________________ Email Address of Authorized User

________________________________ Patient's Name

________________________________ Patient's Date of Birth

Physician's Name (Check One) ☐ Dr. Limvarapuss ☐ Dr. Chaiyarat ☐ Dr. Wexler

Authorized user is (Check One):

☐ Patient ☐ Patient's Guardian

☐ Person authorized to make decisions on behalf of patient (*e.g.* by a medical power of attorney)

________________________________ Authorized Signature

__________________________ Date

________________________________ Signature of Practice Staff
[confirming user's identity and authority]

__________________________ Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	**MRN**
Email in iKM	iKM Consent