

**Dr. Shannon Kluppel**  
**Patient Portal adult consent form**  
***yourhealthfile.com***

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

I \_\_\_\_\_, acknowledge that I am 18 years of age.

The email address I wish to have on file for my patient portal

is \_\_\_\_\_

I authorize the following individuals to have access to my personal patient information

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

Signature \_\_\_\_\_