NEWTOWN INTERNAL MEDICINE
A Functional and Holistic Approach

PATIENT PORTAL ACCESS FORM

We are pleased to make this innovative service available to you. There is no cost to review your patient information on the portal.

Please provide your email address to us and sign the bottom portion of this page giving your consent. An email will be sent to you when the site is available and information on how to access it.

_____
Email Address

I, _____, give permission to Newtown Internal Medicine
(Print Patient's Name)

to use my email address for access to the Patient Portal.

_____ ____/____/____
Signature of Patient / Patient Representative / Legal Guardian Date of Birth (Patient)

_____ ____/____/____
Print name of person signing this Form Today's Date

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