UND SCHOOL OF MEDICINE & HEALTH SCIENCES
UNIVERSITY OF NORTH DAKOTA

Center for Family Medicine

# PATIENT AGREEMENT FOR USE OF THE PATIENT PORTAL

Please complete all fields. Incomplete or illegible forms will not be accepted.

You must present this completed form and provide photo identification in order to register yourself as a proxy.

Once you have registered, for the Patient Portal, you will receive an email invitation from Trinity Health with instructions on how to complete your registration. Please allow up to 5 days for processing.

Patient's Name: _____

Date of Birth: _____ Phone: _____

Email Address: _____

**WARNING:** The e-mail address you choose for your patient portal should be accessible only to you. Be aware that work e-mail addresses are typically the property of the employer and therefore often not secure or confidential. The UND Center for Family Medicine is not responsible for the security or confidentiality of the e-mail address you choose to use.

| Challenge Questions (Choose Only One) | Challenge Answer (Answer Only One) |
|---|---|
| What are the last 4 digits of your SSN? | _____ |
| What year did you get married? | _____ |
| What year did you graduate high school? | _____ |
| What year was your mother born? | _____ |

*The challenge answer is required to complete the Patient Portal proxy registration*

I understand that the Patient Portal is to be used for routine matters. If I have an urgent issue or need a response quickly, I will call my health care provider, go to a nearby emergency department or call 911. I also understand that messages I send to my health care provider will become part of my medical record. I agree that all entries will be truthful and relevant to my health issues, not those of friends or family members.

I understand that the initial invitation to create an account will be sent to the above email address, and that notifications will be sent to that email address to keep me informed of incoming communications on the Patient Portal. I agree to update the Patient Portal with any changes to my email address.

I understand that I will choose my own unique user ID and password. I agree to keep my password confidential, and not share it with anyone as it allows access to my personal health information.

_____ _____

Signature Date

*FOR OFFICE USE ONLY*

A copy of the requestor's photo ID must be attached to this form.

ID verified by: _____ Date: _____

Registration completed by: _____ Date: _____

CFM3

PATIENT LABEL