PRIVIA
MEDICAL GROUP

SHARED PATIENT PORTAL AUTHORIZATION FORM

First Patient's Full Name | **Relationship to Other Patients**

Address | **Patient's Date of Birth**

City,State Zip Code | **Patient's Telephone Number**

Second Patient's Full Name | **Relationship to First Patient**

Address | **Patient's Date of Birth**

City,State Zip Code | **Patient's Telephone Number**

Third Patient's Full Name | **Relationship to First Patient**

Address | **Patient's Date of Birth**

City,State Zip Code | **Patient's Telephone Number**

Fourth Patient's Full Name | **Relationship to First Patient**

Address | **Patient's Date of Birth**

City,State Zip Code | **Patient's Telephone Number**

We, the undersigned patients, hereby request and authorize the disclosure by Privia Medical Group of all of aur protected health information that is contained in out Privia patient portal to the persons specifically listed above.

1. We understand that the information used or disclosed may be subject to re-disclosure by the person(s) receiving it and will then no longer be protected by federal privacy regulations.
2. Any person listed on this Authorization may revoke this authorization ny notifying Privia Medical Group in writing of his or her desire to revoke it. However, we understand that any action already taken in reliance on this Authorization cannot be reversed, and any revocation will not affect those actions.
3. Our Purpose for sharing the information is for:

4. We understand that treatment by a Privia provider may not be conditioned on signing this Authorization.

5. This authorization will not expire or terminate; it will remain in full force and effect unless and until revoked by any person listed on this Authorization.

IMPORTANT: THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

ONLY THOSE INDIVIDUALS WHO HAVE SIGNED THIS AUTHORIZATION WILL HAVE THEIR INFORMATION SHARED VIA THEIR PATIENT PORTAL (EXCEPT THAT A PATIENT OR GUARDIAN MAY BE GIVEN ACCESS TO THE PATIENT PORTAL OF THEIR MINOR CHILD OR WARD)

THIS MAY BE RETURNED TO PRIVIA IN PERSON OR VIA EMAIL, FAX, OR MAIL.

Signature of Patient #1 (or parent or guardian)	**Date of Signature**	**Relationship to Patient (if other than patient)**
Signature of Patient #2 (or parent or guardian)	**Date of Signature**	**Relationship to Patient (if other than patient)**
Signature of Patient #3 (or parent or guardian)	**Date of Signature**	**Relationship to Patient (if other than patient)**
Signature of Patient #4 (or parent or guardian)	**Date of Signature**	**Date of Birth**