Consents/Registration
Greenville Health System

GREENVILLE HEALTH SYSTEM (GHS) PATIENT PORTAL ACCESS

A. Patients 16 years old or older or Emancipated Minors

I desire to participate in the Patient Portal. Email address:_____

Signature of Patient_____Date/Time_____

I authorize proxy access to my Patient Portal to another person. (*if applicable to specific portal)*

Name of Proxy:_____Relationship:_____

Email address:_____DOB:_____

Signature of Patient:_____Date/Time_____

B. Patients 12 to 15 years old

My parent/legally authorized representative and I desire to participate in the Patient Portal.

Patient hereby assents to the terms and conditions for participation in the Patient Portal and to allowing a parent (or legally authorized representative) to be granted proxy access.

Patient's email address:_____DOB:_____

Signature of Patient_____Date/Time_____

Name of parent/legally authorized representative:_____

Email address:_____Relationship:_____DOB:_____

Signature:_____Date/Time_____

C. Patients under 12 years old

I desire to participate in the Patient Portal for my child/ward.

Name of parent/legally authorized representative:_____DOB:_____

Email address:_____Relationship:_____

Signature:_____Date/Time_____

D. Patients unable to consent/assent

I desire to participate in the Patient Portal for the above named patient who is unable to consent/assent.

Name of Proxy:_____Relationship to patient:_____

Email address:_____DOB:_____

Signature:_____Date/Time_____

Appropriate Documentation has been presented to GHS Staff to indicate that the legally authorized representative has authority to sign for the patient.

GHS Staff Signature:_____Printed Name:_____Date/Time:_____

For new information or updates, please fax to 864-454-2539*