



**Full-Service, All Digital Imaging Network**

**Physician Portal Grouping Consent Form**

The following physicians have agreed to allow all members of this group make available all of their respective patient data to one another in accordance with all State and Federal HIPPA laws. All terms of the Physician Portal Terms of Service (TOS) continue to apply.

*Practice Name:*

*Provider Names:*

I consent for the doctors listed above to have access to my patient’s exams and results via the Centrelake Physician Portal.

Provider Signature	_____	Date: _____
Provider Signature	_____	Date: _____
Provider Signature	_____	Date: _____
Provider Signature	_____	Date: _____
Provider Signature	_____	Date: _____
Provider Signature	_____	Date: _____

\*\*\*Must be original signature, no stamp signatures. Blue or Black Ink only\*\*\*

PLEASE DO NOT FAX THIS FORM AS WE REQUIRE ORIGINAL DOCUMENT TO CREATE CREDENTIALS. PLEASE CALL (909) 242-7323 TO ARRANGE PICKUP OF FORMS BY OUR STAFF AT YOUR OFFICE

REV: 122320