



NVRH Patient Portal Enrollment Request

By completing this form, I am requesting access to the Northeastern Vermont Regional Hospital (NVRH) patient portal. I understand that portal access is a secure, optional service that allows me to view certain health information and communicate with NVRH as permitted by policy.

1. Patient Information

Patient Name	Date of Birth	MRN# (if known)
Preferred Email Address (please print):		
Confirm Preferred Email Address (please print):		
Phone Number:		

2. Identity Verification (Required)

<p>Identity was verified using the following method:</p> <p><input type="checkbox"/> Government-issued photo ID reviewed in person</p> <p><input type="checkbox"/> Two identifiers confirmed in person:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Date of Birth <input type="checkbox"/> Address <input type="checkbox"/> Recent visit date or provider name <p><input type="checkbox"/> Phone verification (3 identifiers confirmed):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Date of Birth <input type="checkbox"/> Address <input type="checkbox"/> Last 4 SSN (if on file) <input type="checkbox"/> Recent visit date <input type="checkbox"/> Other: _____
<p>Internal Use Only (HIM):</p> <p><input type="checkbox"/> Enrollment completed</p> <p><input type="checkbox"/> Activation email sent</p> <p><input type="checkbox"/> EMR documentation completed</p> <p>Processed by: _____</p> <p>Date: _____</p>



Choosing Health

**Northeastern Vermont
Regional Hospital**

By signing below, I acknowledge and agree that:

- I will keep my portal username and password confidential and will not share them with anyone.
- I understand that the portal is not to be used for emergencies or urgent medical needs; in an emergency I will call 911 or go to the nearest emergency room.
- I understand that not all parts of my medical record may be available through the portal.
- I consent to receive electronic communications through the portal and the email address listed above, as allowed by law and NVRH’s privacy policies.
- I will notify NVRH promptly if my email address or phone number changes, or if I believe my portal account has been compromised.
- I understand that information in the portal comes from NVRH’s electronic health record and will be updated as new information is available, including laboratory results and imaging reports.
- I understand that use of the portal is voluntary and I do not need to sign this form to receive care at NVRH.

Patient Authorization

Name (print): _____

Signature: _____

Date: ____ / ____ / ____