



- Ocala**
433 SW 10th Street Ocala FL, 34471
Phone (352) 732-4032 • Fax (352) 620-0419
- Timber Ridge**
9401 SW SR 200 Suite 702 Ocala, FL 34481
Phone (352) 237-7170 • Fax (352) 237-8808
- Lady Lake**
13940 US HWY 441 N Lady Lake, FL 32159
Phone (352) 259-8940 • Fax (352) 430-1073

User Electronic Mail Authorization Form (Optional)

Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the “Portal”) offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record; we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand that you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician’s office to update your email contact information so that you will continue to receive updates and other pertinent information about your Portal or your record. Please choose an email address that will not be accessed by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician’s office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name (First Name, Middle Initial, Last Name)

Email Address of Patient/Authorized User

Patient’s Date of Birth

Physician’s Name

Authorized User is:

- Patient
- Patient’s Designee

Patient’s Designee’s Name (Printed)

Patient’s Designee’s Signature

Patient’s Medical Record Number

Patient’s Signature

Date

Signature of Practice Staff
(Confirming User’s identity and authority)

Date