NORTHERN MONTANA HEALTH CARE

PATIENT PORTAL REGISTRATION

REQUIRED INFORMATION: **please print clearly and indicate a zero as Ø**

Name: _____ _____ _____
Last First Middle

Date of Birth: _____ _____ _____
Month Day Year

Medical Record #: _____

E-mail Address: _____

Telephone: (____)_____-_____

By signing and dating this form, I am authorizing Northern Montana Health Care to create a Northern Montana Health Care Patient Portal username and password for me. I understand that this information will be emailed to me within 10 business days at the email address as listed above. I understand that further instructions on logging into the portal will be included in the initial email I receive. Once I have logged into the portal I will be prompted to change my username and password.

I will comply with the terms and conditions on the Patient Portal.

*I understand this is only for **MY** Patient Portal. I must contact the Health Information Management Department at (406)262-1226 for further instructions on how to obtain access to other Patient Portals (i.e. minor children).*

_____ _____
Patient Signature Date

Return to:
Health Information Management
Northern Montana Health Care
P.O. Box 1231
Havre, MT 59501

OR Fax to: 406-265-1639

Portal Set-up: _____ _____
initials date

HIM 0140 02/19

ROIAUTH