Hyden Health Care, PLLC
Buna, Texas

_____ Initials

I,_____, agree to the usage of the Patient Portal to enhance the communication process between Hyden Health Care and myself.
Further, I understand the Patient Portal is certified HIPAA Security compliant.

PLEASE PRINT LEGIBLY

Name: _____ _____ _____
First **Middle** **Last**

Cell Phone #: (_____)_____ Cell Phone Carrier:_____

Date of birth: _____ Email: _____

Signature: _____ Date: _____