



**PEDIATRIC ASSOCIATES AT ARGYLE, P.A.**

**PATIENT PORTAL ACCESS REQUEST FORM**

Parent/Guardian Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient Name(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_