Southwest
Medical Center

PATIENT PORTAL ACCESS REQUEST

PHOTO IDENTIFICATION IS REQUIRED

By affixing my signature hereto, I do hereby notify the Southwest Medical Center, Liberal, Kansas that I am requesting access to the Patient Portal.

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Email Address: _____

_____ _____
Signature Date

_____ _____
Witness Date

Identity confirmed by: Known to staff _____ Driver's license _____ SWMC ID card _____ Other _____