Patient Portal Registration Form- Employee Health Center

Portal Account Classification: (Copies of legal documents or photo ID required)

The Follow My Health patient portal at Employee Health Center is provided by Allscripts and designed to enhance secure patient and provider communication and is provided as a courtesy to our valued patients.

☐ **Independent Adult:**	**I am 18 years or older and request access to my medical record information**
☐ **Self-Assigned Adult Proxy:**	**I am 18 years or older and grant full access to my medical records to the proxy listed below**
☐ **Young Adult:**	**I am 12-17 years of age and request access to my medical record information**
☐ **Young Adult Proxy:**	**I am 12-17 years of age and give full access to my medical records to the proxy listed below**
☐ **Minor Proxy:**	**I am the custodial parent or Legal Guardian of a minor patient less than 12 years of age**
☐ **Dependent Adult Proxy:**	**I am the Legal Guardian and/or Durable Healthcare Power of Attorney for another person**
☐ **Declination:**	**I have received information about the Follow My Health patient portal but am declining access and understand that my refusal will not affect my ability to obtain treatment**

☐ **Either I or my proxy have reviewed and/or have been given a copy of the "FollowMyHealth Universal Health Record Terms of Use". I agree to terms and conditions set forth by the "FMH Universal Health Record Terms and Use" and give permission to enroll me in the FMH patient portal.**

Patient Information: (Please Print) Name: _____
First Name Middle Name Last Name

Address: _____ City and State: _____ Zip: _____

Patient Date of Birth: _____ Social Security #: _____ Phone: _____-_____-_____
MM/DD/YYYY

Email address to receive patient portal messages: _____@_____

I hereby authorize MSMG/NCPS/APP to disclose my protected health information to the Follow My Health (FMH) patient portal for online access to my healthcare information or the individual listed below. If I elect to designate a Proxy to my FMH account, I am authorizing the Proxy access to health information in my FMH account. I understand the FMH patient portal may contain sensitive data including, but not limited to, testing, evaluating, and diagnosing, and/or treatment of sexually transmitted diseases, HIV/AIDS, birth control, pregnancy or family planning, alcohol and/or drug dependency or addiction, behavioral or mental health and genetic screening tests. I understand that, if the persons I authorize to receive and/or use the health information described in this form are not health plans, covered healthcare providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the health information and it may no longer be protected by federal or state health laws. This authorization is in effect until my FMH account is inactivated and includes records that were created or existing prior to the date this authorization was signed, as well as, records that are created after the date this authorization was signed. I understand my portal access can be discontinued at any time by email: FollowMyHealthSupport@msha.com or by calling 423-302-2695 or toll free 844-695-6742.

Patient Signature: _____ Date: _____

**** Proxy access is automatically removed when a minor reaches the age of 12 years old ****
Individual who will be given access to health information for a Young Adult, Minor, Adult, or Dependent

Proxy/Legal Guardian and/or Durable Healthcare Power of Attorney:

Proxy Information: (Please Print) Proxy Name: _____
First Name Middle Name Last Name

Proxy Date of Birth: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address to receive PROXY portal messages: _____@_____

Address: _____
Street Address City, State Zip Code

Home Phone: _____-_____ -_____ Cell Phone: _____-_____-_____

I certify my relationship as indicated herein and request MSMG/NCPS/APP to disclose health information to the FMH patient portal for the patient identified above. I understand my proxy portal access can and will be terminated immediately upon discovery or proof of misrepresentation of my relationship to the patient. I agree to notify MSMG/NCPS/APP if legal guardianship or an activated Durable Power of Attorney for Healthcare becomes invalid for any reason.

Proxy Signature: _____ Date: _____

Photo Id & Copies of Legal Documents Verified By: _____ Date: _____