



## FollowMyHealth PATIENT PORTAL REGISTRATION

*24/7 access to your medical records*

Email completed form to [FollowMyHealth@i-Health.com](mailto:FollowMyHealth@i-Health.com).

**ACCEPT FREE SERVICE:** Please complete the fields below. This will allow you direct access to your health history and a clinical summary of your physician office visits.

### I AM THE:

☐ Patient (complete this side) ☐ Proxy (authorized healthcare decision maker, complete reverse side)

*If spouse, parent, legal guardian, or anyone besides the patient is requesting access to the patient's records, please complete the reverse side. Only the patient should complete this side.*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

### Signature / Access Code:

*You will receive an email inviting you to register for "FollowMyHealth" within the next 2 business days. If you do not activate this on-line service within 90 days, i-Health will note that you declined these services.*

**\*\*\* Your initial access code will be the 4 digit year in which you were born. E.g., 1973 \*\*\*** Please make note of this. You will need that access code during the email registration process.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Office Use Only:

Filed by: \_\_\_\_\_

- A proxy is a person who is 18 years of age or older who can access your information as if they were you
- A spouse, adult child, or a caregiver can be granted full access to your medical records with proxy access.
- In order for a proxy to view information in FollowMyHealth, please complete the form below.
- Authorization for proxy access to an adult patients account is valid until revoked by the patient.
- Authorization for proxy access to a child account is valid until the child turns 18.

### 1. Patient Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### 2. Proxy Information

Name \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Proxy's Email Address: \_\_\_\_\_

#### Relationship to Patient:

\_\_\_\_\_ Custodial Parent

\_\_\_\_\_ Legal Guardian

\_\_\_\_\_ Spouse

\_\_\_\_\_ Non-Custodial Parent

\_\_\_\_\_ Durable Power of Attorney for Healthcare (DPOA)

\_\_\_\_\_ Caregiver for Senior Parent

\_\_\_\_\_ Other (specify) \_\_\_\_\_

#### AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

- I authorize i-Health to release medical information via FollowMyHealth to the designated proxy names above. The following information is to be released: Any and all information as allowed through FollowMyHealth.
- I understand that I have the right to revoke this authorization at any time.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus - HIV). It may also include information about behavioral health or mental health services and treatment for alcohol and drug abuse
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by government confidentiality rules. If I have questions about the disclosure of my health information, I can contact i-Health.
- I understand this authorization must be filled out completely and signed and dated in order to be considered valid, and activation of the FollowMyHealth proxy access feature must occur within thirty days from the date of this authorization

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date