GRAND LAKE™ HEALTH SYSTEM

Patient Portal Account Access Form

Thank you for your interest in the FollowMyHealth patient portal, made available by Grand Lake Health, to provide a convenient and secure way for patients to manage their personal health record from any computer or mobile device with internet access.

Instructions for Completing this Form

To sign up for access to your health information in FollowMyHealth, please complete this Access Form. You will receive an email with an invitation to join FollowMyHealth and step by step instructions to complete the process. A separate form will need completed for each patient requesting/granting access.

Your Information: (All sections required in order to receive an invitation – please print clearly.)

Patient Name: ________________________________ Patient Birth Date ____ /____ /____ Sex: M □ F□

Patient Address: ____
(Street) (City) (State) (Zip Code)

Patient Phone:______________________________ Patient Email: ______________________________

ACCESS TYPE
□ **Minor child Proxy (age 13 or younger) –** must have authorization signed by parent/legal guardian
□ **Minor child Proxy (age 14 to 17) –** must have authorization signed by patient (minor patient) • **for parent or legal guardian** □ **I grant full access** □ **I grant the standard limited access**
□ **Minor personal access (age 14 to 17) –** must have authorization signed by patient (minor patient) • **for patient's personal access**
□ **Adult Proxy (age 18+) –** must have authorization signed by patient • **for adult to grant another individual full access to their portal**
□ **Adult Personal Access (age 18+) –** Simply provide email address at time of check-in/registration – OR have authorization signed by patient.
To have access granted to the patient portal return this Patient Portal Account Access Form to one of the following: Grand Lake physician practice, medical records department at JTDMH or fax to 419-394-3692

INFORMATION FOR PROXY REQUESTING ACCESS (Proxy access is providing access to your patient information on the FollowMyHealth patient portal to someone other than yourself)

Proxy Name: ______________________________________ Proxy Birth Date ____ /____ /____

Proxy Address: ____
(Street) (City) (State) (Zip Code)

Proxy Phone:____________________________ Proxy Email: ______________________________

Relationship to Patient: □ Mother □ Father □ Spouse □ Guardian □ POA □ Attorney □ Other

AUTHORIZATION: Permission is hereby granted to Grand Lake Health to release medical information via the Grand Lake Health FollowMyHealth® Patient Portal, to the individual as identified above.

Responsible Party Signature: ______________________________________ Date:__________________

Relationship to patient: □ Self □:____

FOR INTERNAL USE ONLY

□ Reviewed and verified form. ________ initials Patient MRN:______________________

□ Access initiated in EHR________ initials □ Form sent for scanning into EHR ________ initials