Hospital *for* Special Care

We Rebuild Lives.

FollowMyHealth® Authorized Individual Form

(Patient 18 Years or Over)

To request access to FollowMyHealth® medical record portal, of a patient whose medical care you help manage, please complete this form and return it to the **Health Information Management (HIM) Department**.

Patient Information

Patient Name ______________________ DOB ___/___/___ Email ______________________

Patient Phone # ______________________ Cell ______________________

Address ______________________ Last 4 Digits of SSN ________

Patient Authorized Individual Information

Authorized Individal Name ______________________ Relationship ______________________

DOB ___/___/___ Email ______________________

Patient Phone # ______________________ Cell ______________________

Address ______________________ Last 4 Digits of SSN ________

Patient Authorized Individual Agreement to FollowMyHealth Terms and Conditions

As a Patient Authorized Individual designed by the patient named above, I understand and agree to the following:

- FollowMyHealth® contains selected, limited medical information from the patient's medical record and does not reflect the complete contents of the medical record. A paper copy of a patient's medical record may be requested from the Hospital for Special Care (HSC) Health Information Management Department.
- My activities within FollowMyHealth® are tracked by computer audit, and entries I make can become part of my medical record or the above-named patient's medical record.
- I understand that my access to any information about the patient may be revoked by the patient or terminated by Hospital for Special Care at any time without notice.
- I agree to abide by the Hospital for Special Care FollowMyHealth® Terms and Conditions, which are available on the HSC website (www.hfsc.org).
- By signing below, I acknowledge that I am providing documentation of my authorization to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

Patient Authorized Individual Signature **Date** / /

Patient Acknowledgement

I acknowledge that I have read and understand this FollowMyHealth® Patient Authorized Individual Access Authorization form. I agree to its terms and designate the person named above as my FollowMyHealth® Patient Authorized Individual, thereby allowing him/her access to my FollowMyHealth medical record.

Patient Signature **Date** / /

FollowMyHealth®
An Allscripts Solution

Health Information Management
ROI@hfsc.org / 860.827.4863
2150 Corbin Avenue
New Britain, CT 06053