hfsc Hospital for Special Care

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 Individual 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
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