Office Use Only:
Acct #: _____
DOB: ____ / ____ / _____

iHealth
Infinite Health Collaborative

FollowMyHealth PATIENT PORTAL REGISTRATION

24/7 access to your medical records

DECLINE FREE SERVICE: To decline this service please initial here: _____

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: _____
(please print legibly)

Signature

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, the invitation will expire.

_____ _____
Signature of Patient Date

FollowMyHealth - Proxy Access

iHealth
Infinite Health Collaborative

Giving Others Access to Your Medical Records

- 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:

_____Mother _____Father _____Step Mother _____Step Father
_____Guardian _____Spouse _____ Power of Attorney
_____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