# AUTHORIZATION FOR RELEASE OF COVID-19 RESULTS and ACCESS TO FollowMyHealth

Patient Name/Patient Label:________________________________________ Birth Date: ________________________________

Date of Test:__________________________________________________ Phone No: ________________________________

## Receive your results one of three ways:

### Option 1 (*FASTEST*) Access Patient Portal:

You will typically receive instructions on accessing FollowMyHealth via email within two business days

Email for FollowMyHealth: ____________________________________ Birth Date: ________________________________

Email Recipient Name if NOT the Patient __________________________ Phone No:________________________________

Address: _______________________________________________________

_______________________________________________________

### Option 2: Mail or Fax Results To You

Fax No:________________________________________

Address:

_____________________________________________

_____________________________________________

### Option 3: Send Results To (If NOT the Patient):

Name: _______________________________________________________ Phone No:_______________________________

Address: _____________________________________________________ Fax No:_________________________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Dept. Director. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- This authorization for access or release is valid for 1 (ONE) YEAR from the date of the signature,
- By law, WRH has 30 days to provide copies of records.
- You will receive a phone call if your authorization is unsigned or otherwise incomplete and/or if we are unable to complete your request
- Results can take up to 7 days

AUTHORIZING SIGNATURE:_____________________________________________DATE:___________________________

Signed by:________Patient________Legal Guardian__________Executor of Estate_________Other (specify) ____________________________

I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal privacy laws and regulations. Rev04.03

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Entrance Staff/MR Initials _______/______

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1900 23rd Street, Cuyahoga Falls, OH 44223 P: (330) 971-7414 F: (330) 971-7087 wrhmedicalrecords@westernreservehospital.org