AUTHORIZATION FOR ACCESS TO FollowMyHealth PATIENT PORTAL

Patient Name: _____ Birth Date: _____

Address: _____ Phone No: _____

_____

Send Information to (if not the patient): _____ Birth Date: _____

Address: _____ Phone No: _____

_____

Email address: _____

AUTHORIZING SIGNATURE: _____ DATE: _____

Signed by: _____Patient _____Legal Guardian* _____Executor of Estate* _____Other (specify)* _____

*Please submit supporting documentation if signed by anyone other than the patient.

Instructions:

Please print, complete, sign and date this form. A copy of your Driver's License/ State Photo I.D. is also required.

You may either fax, email or bring in your completed and signed FMH Authorization form AND a copy of your Driver's License/ State Photo I.D. to:

Fax: (330) 971-7087

Email: wrhmedicalrecords@westernreservehospital.org

Address:
Medical Records Dept.
Western Reserve Hospital
1900 23rd Street
Cuyahoga Falls, OH 44223

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

You will receive a phone call if your authorization is unsigned or otherwise incomplete and/or if we are unable to complete your request.

If you have any questions, please call us at: 330-971-7375