AUTHORIZATION FOR ACCESS TO FollowMyHealth PATIENT PORTAL

Patient Name:	
	-
Send Information to (if not the patient):	Birth Date:
Address:	
Email address:	-
AUTHORIZING SIGNATURE:	DATE:
Signed by:PatientLegal 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	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

1900 23rd Street, Cuyahoga Falls, OH 44223 P: (330) 971-7375 F: (330) 971-7087

Wrhmedicalrecords@westernreservehospital.org

Release of Information Office is Opened 8:30a - 5:00p M-F

