# AUTHORIZATION FOR ACCESS TO FollowMyHealth PATIENT PORTAL

Patient Name: _____

Address: _____

_____

Email address: _____

Birth Date: _____

Phone No: _____

Send Information to *(if not the patient)*: _____

Address: _____

_____

Email address: _____

Birth Date: _____

Phone No: _____

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

1900 23rd Street, Cuyahoga Falls, OH 44223

**P: (330) 971-7375** **F: (330) 971-7087**

**Wrhmedicalrecords@westernreservehospital.org**

**Release of Information Office is Opened 7:00a – 3:00p M-F**

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Partnering with University Hospitals