FOLLOW MY HEALTH PATIENT PORTAL INVITATION REQUEST FORM

Thank you for printing the following information:

Patient Name: _____

Patient's Date of Birth: _____

Address: _____

_____

Email Address: _____

Phone Number: _____

By signing this request form, I acknowledge and agree that:

- I am giving my permission for Cornerstone Pediatric & Adolescent Medicine to disclose my protected health information (PHI) through FollowMyHealth Patient Portal, which may include, but may not be limited to: my health summary, current problem list, current medications, lab results and my appointment information. I understand that if I grant proxy access to my parent/guardian, he/she will be able to view and make updates to any information that is posted to my person health record in FollowMyHealth.

_____ _____

Patient Signature Date

For Office Use Only:

Chart Number	Date Invited	Employee Initials

Updated: 06/27/2017