



**PATIENT PORTAL ENROLLMENT REQUEST**  
**(All fields must be completed)**

Name on Record: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

(This email address is where your patient portal login information and other patient portal communication will be sent. Please be sure that this is an active email account, and that you are comfortable with this type of information being sent to that address.)

By completing this form, I authorize that I am requesting access to Warner Hospital & Health Services MY Health patient portal. I understand that upon completion of this form, I will receive log-in instructions to the Patient Portal within 5 business days within Warner Hospital & Health Services receipt of this form, at the email address I identified above. I understand that the Patient Portal will include my private health information. I understand that once information is disclosed onto the Patient Portal, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that requesting access to Warner Hospital & Health Services MY Health Patient Portal is voluntary, and that I need not sign this authorization to receive healthcare treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please Return Completed Form To:  
Attn: Health Information Management Department  
Warner Hospital & Health Services  
422 W. White St.  
Clinton, IL 61727  
OR: [himquality@warnerhospital.org](mailto:himquality@warnerhospital.org)

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**Warner Hospital & Health Services Health Information Management Department Use Only:**

Medical Record Number: \_\_\_\_\_

Entered in Meditech: \_\_\_\_\_  
Date

Completed By: \_\_\_\_\_  
Signature