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 & Time

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

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

Medical Record Number: _____

Entered in Meditech: _____
Date & Time

Completed By: _____
Signature