Adult Consent

Notice: This is a HIPAA Agreement Form

Thank you for expressing interest in the FollowMyHealth® patient portal. The Hutchinson Clinic looks forward to your participation!

To request access to your health information using FollowMyHealth®, please complete this "Adult Consent." After your information is verified, you will receive an email invitation from noreply@followmyhealth.com. Within this email you will also find your invitation code that has been assigned to you.

HIPAA: The federal **Health Insurance Portability and Accountability ACT** (HIPAA) of 1996, along with state law, mandates the privacy and security of Protected Health Information (PHI); the portability of health insurance and simplification of electronic billing.

- The information you are requesting access is Protected Health Information (PHI). Having access allows you to view your entire PHI. The Hutchinson Clinic will not be responsible for a HIPAA breach determined to be intentional by user or occurred outside of the Hutchinson Clinic.

By completing and signing this form:

1. I certify that I am said person below.
2. I authorize the Hutchinson Clinic to enroll me in FollowMyHealth® patient portal.
3. I authorize the Hutchinson Clinic to use the provided email address to send my email invitation.
4. I understand that additional information may be made available to me through the patient portal in the future.
5. I understand that this form only gives me access to my health record. This form does not authorize the release of my medical record by other methods or in other formats. To request copies of my medical record, the Health Information Department will need to be contacted.
6. I understand that access to my patient portal is provided by Hutchinson Clinic as a convenience to its patient's. Hutchinson Clinic has the right to deactivate access to the portal at any time, for any reason.

PATIENT INFORMATION

Name: ________________________________ **Patient #:** ______________________

Phone: __________________________ **DOB:** ______________

Street Address: ______________________________ **City, State, and Zip Code:** ______________________

Email Address: __________________

PATIENT'S SIGNATURE: ____

ADDITIONAL ACCOUNT USER(S)

By completing this section, I am requesting the Hutchinson Clinic to give access to the following individual(s):

Name: _____________________________ **Phone:** _______________________

Street Address: ___________________________ **City, State, and Zip Code:** ____________________

DOB: ___________ **Email Address:** _________________

Relationship to Patient: ___________ __________ **Other (Specify)**

Access Level: ___ **Full Access** ___**Read Only Access**

For office use only:

ID Verified by (print name): ____________________________ **Date Invitation sent:** ______________________________