The FollowMyHealth™ patient portal at the Infectious Disease of Indiana is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Infectious Disease of Indiana to email an invitation to create a portal account.

Purpose for Access:	**PERSONAL ACCOUNT ACCESS:** ***(photo ID required)***
	☐ I am 14-17 years of age and request access to my own medical record information
	☐ I am 14-17 years of age and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 14-17 years of age and grant Full Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and request access to my own medical record information
	☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: ***(copies of legal documents and photo ID required)***
	☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)*:

Patient Name: ______________________________

FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: ______________ Phone: ______________

MM/DD/YYYY

Email address where patient portal messages will be sent: ______________________________

(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Infectious Disease of Indiana to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Infectious Disease of Indiana health care information:

Patient Signature: ______________________________ Date: ______________

Authorized User Information (*please print)*: (Person receiving access to a Patient Portal account)

Authorized User Name: ______________________________

FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: ______________ Relationship to Patient: ______________

MM/DD/YYYY

Email address where Authorized User portal messages will be sent: ______________________________

(PERSONAL EMAIL RECOMMENDED)

Address: ______________________________

STREET ADDRESS CITY, STATE ZIPCODE

Home phone: ______________ Cell phone: ______________

Authorized User Signature: Date:

For Front Desk Use Only	
Photo ID & Copies of Legal Documents Verified By:	Date:
For Portal Use Only	
Patient Portal Invite sent by:	Date:
(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)	