FollowMyHealth Patient Portal Adult/Adult Access Application

(Adult Access to the Electronic Medical Record of another Adult)

Mercy Iowa City Hospital and Clinics(MIC)
Health Information Management, Release of Information Office, 500 E. Market St. Iowa City, IA 52245

Telephone: 319-339-3609; Fax: 319-339-3785; Email: PatientPortalAdmin@MercyIC.org
(a separate form is required for each adult patient):

Patient's full legal name _____ Patient's Date of birth _____

Mailing address _____ City _____ State _____ Zip code _____

1) Authorized **Individual** information:

Individual's full legal name _____ Date of birth _____ Phone number _____

Mailing address _____ City _____ State _____ Zip code _____

Email address _____

2) If applicable, Secondary Authorized **Individual** information:

Individual's full legal name _____ Date of birth _____ Phone number _____

Mailing address _____ City _____ State _____ Zip code _____

Email address _____

Proxy access allows an adult to have access to an adult patient's patient portal. By completing and returning this form, I am allowing the individual(s) named above to have proxy access to my Mercy Iowa City Medical Record via FollowMyHealth.
By completing and signing this form:

1. I understand that any individuals that I name will have online access to personal health records (PHR) and it may include information, including, but not limited to, future and past treatments I may have received for substance abuse, mental health, HIV-related conditions, and other sensitive information.
2. I understand this consent is voluntary and if I cancel this consent at a later date I must notify Health Information Management listed above. I understand that information may have been released prior to the cancellation and that action would not be considered a breach of confidentiality.
3. I understand that recipients of this information may possibly release the information without proper authorization and once it is disclosed it may no longer be protected by federal privacy regulations.
4. I understand that this form only allows access to Mercy Iowa City's electronic patient portal and does not authorize the release of the patient's medical record by other methods or in other formats.
   (To request copies of the patient's medical record, please contact the Release of Information Department at 319-339-3785)
5. I understand this electronic access will be in effect until revoked by the patient and ends at the time of death.
6. I understand that access to the patient's PHR is provided by Mercy Iowa City as a convenience to its patients. Mercy Iowa City has the right to deactivate access to the PHR at any time, for any reason.

Patient's signature* _____ Date _____

Complete mailing address _____ City _____ State _____ Zip code _____

Relationship _____ Witness signature _____

*If not signed by the patient, list relationship, include witness signature, and legal documentation is required.

Once completed, return to provider's office, registration staff or email: PatientPortalAdmin@MercyIC.org

Internal use only: Verified and processed by: _____ Date: _____

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