

The FollowMyHealth™ patient portal at the **Pulmonary Consultants & Primary Care Physicians Medical Group Inc.** 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 **Pulmonary Consultants & Primary Care Physicians Medical Group Inc.** to email an invitation to create a portal account.

Purpose for Access:	PERSONAL ACCOUNT ACCESS: (photo ID required)		
	<input type="checkbox"/> I am 18 years or older and request access to my own medical record information		
	<input type="checkbox"/> I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below		
	<input type="checkbox"/> 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)		
	<input type="checkbox"/> I am 18 years or older and request Read Only Access to a medical record (<i>indicate legal status below</i>)		
	<input type="checkbox"/> I am 18 years or older and request Full Access to a patient medical record (<i>indicate legal status below</i>)		
<input type="checkbox"/> I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient			
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: _____			
<i>(PERSONAL EMAIL RECOMMENDED)</i>			
I hereby authorize Pulmonary Consultants & Primary Care Physicians Medical Group Inc. to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Pulmonary Consultants & Primary Care Physicians Medical Group Inc. 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: _____			
<i>(PERSONAL EMAIL RECOMMENDED)</i>			
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: _____
<i>(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)</i>			

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