CMH Community Memorial Hospital

PATIENT PORTAL ENROLLMENT REQUEST FORM

Specialty Clinic

(Must be 18 yrs of age & All fields must be completed)

Name on Record:_____

Date of Birth: _____ **Phone #:**_____

Address: _____

City: _____**State:** _____ **Zip:**_____

Email Address*:_____

*A valid email address is required in order to utilize the CMH Specialty Clinic Portal. Please provide a current, personal, private/non-shared email address that only you have access to and verify its accuracy. By providing the email address above, you agree to have CMH communicate with you regarding your Specialty Clinic Portal via email.

Acknowledgment

By completing this form, I authorize that I am requesting access to my health information in the CMH Specialty Clinic Portal. I understand that by providing the email address above, I agree to have CMH communicate with me regarding my Specialty Clinic Portal via email. I understand that upon completion of this form, I will receive log-in instructions to the Patient Portal 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 Community Memorial Hospital's Specialty Clinic Patient Portal is voluntary.

I hereby affirm that I am the patient identified above. I understand that I may be subject to penalties under law for submitting false or misleading information.

_____ _____

Signature Date

If you need to mail in this form, please mail to: Health Information Services Dept
Community Memorial Hospital
512 Skyline Blvd
Cloquet, MN 55720

CMH USE ONLY:

Medical Record Number: _____

Identification of patient verified? Y / N (circle one) Method (circle one): Photo ID / Compare Signature / Other: _____

Entered in eCW: _____ Completed By: _____

Date Staff Signature / Initials