CMH Community Memorial Hospital

PATIENT PORTAL ENROLLMENT REQUEST FORM

(Must be 18 years of age and all fields must be completed)

Name on record: _____

Date of birth: _____ Phone #: _____ Sex: M / F / Other _____

Address: _____

City: _____ State: _____ Zip code: _____

Email address*: _____

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

I want access to these portals (check all that apply):

☐ CMH Hospital ☐ CMH Specialty Clinic ☐ CMH Raiter Family Clinic

Acknowledgement

By completing this form, I authorize that I am requesting access to my health information in My CMH Health Portal. I understand that by providing the email address above, I agree to have CMH communicate with me regarding My CMH Health 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 My CMH Health 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.

_____ _____

Patient Signature Date

If you need to mail in this form, please mail to:

Health Information Management Department - 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:

☐ Meditech (Date) _____ Completed by (staff name/signature) _____

☐ Sp. eCW (Date) _____ Completed by (staff name/signature) _____

☐ RC eCW (Date) _____ Completed by (staff name/signature) _____