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

Purpose for Access:	**PERSONAL ACCOUNT ACCESS: *(photo ID required)***
	☐ I am between the ages of 12-17 and I request access to my own medical record information
	☐ I am between the ages of 12-17 and I grant Read Only Access to my medical records to the authorized user listed below
	☐ I am between the ages of 12-17 years of age and grant Full Access to my medical records to the authorized user listed below
	☐ I am 18 years old or older and request access to my own medical record information
	☐ I am 18 years old or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years old 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 old or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years old 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 Olean Medical Group to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to https://omg.followmyhealth.com.

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)