Patient First Name: _____

Patient Last Name: _____

Acct #: _____

DOB: _____/_____/_____

Phone Number: _____ - _____ - _____

TWIN CITIES ORTHOPEDICS

Follow My Health

PATIENT PORTAL REGISTRATION

Accept Service: Complete the fields below. This will allow you to have access to your health history, your appointment reminders, and a clinical summary of your physician office visits.

Are you the patient?

☐ Yes (Complete this side)

☐ No (Complete the backside)

******Parents, legal guardians, or anyone besides the patient requesting access to the patient's records******

Email: (Please print clearly and legibly) :

Signature / Access Code:

You will receive an email inviting you to register for "Follow My Health" within the next 2 business days. If you do not activate this on-line service within 30 days, TCO will note that you declined these services.

****** Your initial access code will be the 4 digit year in which you were born. E.g.,1973 ****** Please make note of this. You will need that access code during the email registration process.

_____

Signature of Patient Date

Decline Service: To decline this service please initial here: _____

Office Use Only:

Entered in PACE: _____ Invitation Sent by: _____

Twin Cities Orthopedics
Follow My Health Proxy Access

Giving others access to your medical records

- A proxy is a person who is 18 years of age or older who can access your information as if they were you
- A spouse, adult child, or a caregiver can be granted full access to your medical records with proxy access.
- In order for a proxy to view information in Follow My Health, please complete the form below.
- Authorization for proxy access to an adult patients account is valid until revoked by the patient.
- Authorization for proxy access to a child account is valid until the child turns 18.

1. Patient information

Name_____Birthdate_____

Home Phone_____

2. Proxy information

Name_____Birthdate_____

Address: _____

City: _____State:_____ Zip Code_____

Home Phone_____

Proxy's Email address: *(Please print clearly and legibly) :*

Relationship to patient:

_____Custodial Parent _____Legal Guardian _____Spouse
_____Non-Custodial Parent _____Durable Power of Attorney for Healthcare (DPOA)
_____Caregiver for Senior Parent _____Other (specify)_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

- I authorize Twin Cities Orthopedic to release medical information via Follow My Health to the designated proxy names above. The following information is to be released: Any and all information as allowed through Follow My Health.
- I understand that I have the right to revoke this authorization at any time.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus :HIV). It may also include information about behavioral health or mental health services and treatment for alcohol and drug abuse
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by government confidentiality rules. If I have questions about the disclosure of my health information, I can contact Twin Cities Orthopedics.
- I understand this authorization. must be filled out completely and signed and dated in order to be considered valid, and activation of the Follow My Health proxy access feature must occur within thirty days from the date of this authorization

_____ _____

Patient/guardian signature Date