EAST TENNESSEE STATE UNIVERSITY

QUILLEN ETSU PHYSICIANS

# Patient Portal Registration Form

| **Portal Account Classification:** (Copies of legal documents or photo ID required) | |
|---|---|
| **Independent Adult:** | ☐ I am 18 years or older and request access to my medical record information |
| **Self-Assigned Adult Proxy:** | ☐ I am 18 years or older and grant full access to my medical records to the proxy listed below |
| **Young Adult:** | ☐ I am 13-17 years of age and request access to my medical record information |
| **Young Adult Proxy:** | ☐ I am 13-17 years of age and give full access to my medical records to the proxy listed below |
| **Minor Proxy:** | ☐ I am the custodial parent or Legal Guardian of a Minor patient ages 12 or younger |
| **Dependent Adult Proxy:** | ☐ I am the Legal Guardian and/or Durable Healthcare Power of Attorney for another person |

## Patient Information: (please print)

Patient Name: _____
First Name Middle Name Last Name

Patient DOB: _____ Phone: (____)_____
MM/DD/YYYY

Email address to receive patient portal messages: _____@_____

***I hereby authorize Quillen ETSU Physicians to use/disclose my protected health information to the FollowMyHealth™ patient portal for online access to my healthcare information for myself or the individual listed below. I understand the FollowMyHealth™ patient portal contains sensitive data including, but not limited to, testing, evaluating, and diagnosing, and/or treatment of sexually transmitted diseases, HIV/AIDS, birth control, pregnancy or family planning, alcohol and/or drug dependency or addiction, behavioral or mental health and genetic screening tests. I understand my portal access can be discontinued at anytime by contacting portalhelp@getsu.org.***

Patient Signature: _____ Date: _____

## Proxy Information: (please print)

Individual who will be given access to PHI for a Young Adult, Minor, Adult, or Dependent

Proxy Name: _____
First Name Middle Name Last Name

Proxy DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address to receive **PROXY** portal messages: _____@_____

Address: _____
Street Address City, State Zip Code

Home Phone: (____)_____ Cell Phone: (____)_____

***I certify my relationship as indicated herein and request Quillen ETSU Physicians to use/disclose protected health information to the FollowMyHealth™ patient portal for the patient identified above. I understand my proxy portal access can and will be terminated immediately upon discovery or proof of misrepresentation of my relationship to the patient.***

Proxy Signature: _____ Date: _____

| **For Front Desk Use Only** | |
|---|---|
| Photo ID & Copies of Legal Documents Verified By: | Date: |
| **For Portal Management Use Only** | |
| Patient Portal Invite Sent By: | Date: |