QUILLEN ETSU PHYSICIANS
EAST TENNESSEE STATE UNIVERSITY

Patient Portal Registration Form

Portal Account Classification: (Copies of legal documents or photo ID required)	
Adult Age 18 or Older (or Emancipated Minor):	☐ I request access to my medical information through the FollowMyHealth™ Patient Portal.
Adult Age 18 or Older (or Emancipated Minor) Proxy:	☐ I *grant* access to my medical information through the FollowMyHealth™ Patient Portal to the proxy listed below.
Minor/Adolescent Age 14 through 17:	☐ I request access to my medical information through the FollowMyHealth™ Patient Portal.
Minor/Adolescent Age 14 through 17 Proxy (*for medical exceptions only*):	☐ I am the custodial parent or legal guardian of a minor patient age 14 through 17 with a medical exception and request access to the minor patient's medical information through the FollowMyHealth™ Patient Portal. ***This access must be approved by the clinic manager.***
Infant through Age 13 Proxy:	☐ I am the custodial parent or legal guardian of a minor patient age 13 or younger and request access to the minor patient's medical information through the FollowMyHealth™ Patient Portal.
Dependent Adult Proxy:	☐ I am the legal guardian and/or durable healthcare power of attorney for another adult and request access to the dependent adult's medical information through the FollowMyHealth™ Patient Portal.
Declination:	☐ I received information about the FollowMyHealth™ Patient Portal but am declining access and understand that my refusal will not affect my ability to obtain treatment.

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 disclose my protected health information to the FollowMyHealth™ Patient Portal to enable online access to my healthcare information for myself and/or the individual proxy listed below. I understand the FollowMyHealth™ Patient Portal may contain 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 and that if I choose to grant proxy access to my FollowMyHealth™ Patient Portal my proxy may have access to this same health information. I understand my, or my proxy's, portal access can be discontinued at any time by contacting portalhelp@getsu.org.

Patient Signature: _____ Date: _____

Proxy Information: (please print)
Individual who will be granted access to the FollowMyHealth™ Patient Portal of another as indicated on this form

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 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, at the request of the patient, or if otherwise permitted by law.

Proxy Signature: _____ Date: _____

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: Date:

The FollowMyHealth™ Patient Portal at Quillen ETSU Physicians is provided by Allscripts and designed to enhance secure patient and provider communication.
The FollowMyHealth™ Patient Portal is provided as a courtesy to our valued patients.