To request access to MyHealth, please complete this form and return it to the address provided. ***All sections must be completed. Please print clearly.***

Patient Information:

Patient Name: *last,* ______________________ *first,* ______________________ *middle initial,* ________

Date of Birth: ____________________ Age: __________ Last four digits of SSN: ____________________

Street Address: ________________________ City: ______________ State: ______ Zip: __________

Home Phone: ____________________________ Cell Phone: ____________________________

Email Address: ____

Physician Name: ________________________ Mother's Maiden Name: ________________________

Insurance Membership ID: ____________________ Group #: ______________ ☐ I do not have insurance

I allow Essentia Health and its independent Community Connect customers to release my personal health information to me via an online MyHealth account. I will be able to access information maintained in MyHealth for my personal use.

I understand that:

- This authorization will be valid for as long as I maintain an active MyHealth account.
- If I change my mind and no longer want MyHealth access, I may let Essentia Health and its independent Community Connect customers know in writing at any time. This change will become effective no later than the next business day after the date that Essentia Health and its independent Community Connect customers affiliates receives my request and will not apply to information that has already been released before this effective date.
- Essentia Health and its independent Community Connect customers cannot be responsible for the confidentiality of information released to me, and cannot prevent me from releasing the information to another person. At that time, the information is no longer protected by federal and state privacy regulations.
- If I do not sign this form I will still be treated and payment, enrollment and eligibility for benefits will not be impacted.
- To be valid, this form must be completely filled out, signed, and dated. A photocopy, fax or electronically scanned and transmitted image is the same as the original.
- I can receive a signed copy of this form upon my request.
- To complete the MyHealth enrollment process and gain access to a MyHealth account, I must activate the account with the code I will be or already have been given. As part of this on-line activation process I will be asked to confirm that I have read and agree to the MyHealth Terms and Conditions. I understand that every time I use MyHealth I agree to these Terms and Conditions.
- I designate my MyHealth account as my preferred method of communication.

____ _____ /_____ /_____

Signature of Patient Today's Date

Return completed form to:

Email: MyHealthSignup@EssentiaHealth.org

Mail: Health Information Services – West Annex - HIS - 45
400 E. Third St.
Duluth, MN 55805

Fax: 218-786-6658

Essentia Health

MyHEALTH Access Self-Authorization
For Age 12 and above
EH10316 06/17