Follow My Health

PROXY AGREEMENT FOR USE OF FOLLOWMYHEALTH

Patient's Name (Please print) ______________________ Last ______________________ First Patient's Date of Birth ______________________ MM/DD/YYYY

Proxy's Name (Please print) ______________________ Last ______________________ First Proxy's Phone Number ______________________

Proxy's Relationship to Patient ☐ Parent ☐ Guardian ☐ Spouse ☐ Power of Attorney ☐ Other: ______________________

Proxy's Email address ______________________

Proxy's Home address ______________________ Street ______________________ City ______________________ State ______________________ Zip

I would like to register as a proxy for the FollowMyHealth patient portal account provided by St. Mary's of Michigan and St. Joseph Health System, which will allow me to:

- View the patient's medical records
- View the patient's medical information such as allergies, medications and immunizations
- View the patient's lab results, discharge summaries and educational materials
- Request and review appointments for the patient
- Request renewals of the patient's prescriptions
- Communicate securely with health care providers on behalf of the patient

I understand that FollowMyHealth is to be used only for routine matters. If the patient has an urgent issue or needs a response quickly, I will call their health care provider, send them to a nearby emergency department or urgent care center, or call 911. I also understand that messages sent to the patient's health care provider will become part of the patient's medical record. I agree that all entries will be truthful and relevant to the patient's health issues, not those of friends or family members.

I understand that the initial invitation to create an account will be sent to the above email address, and that notifications will be sent to that email address to keep me informed of incoming communications on FollowMyHealth. I agree to update FollowMyHealth with any changes in my email address.

I understand that I will choose my own unique user ID and password. I agree to keep my password confidential, and not share it with anyone, because it allows access to the patient's personal health information. **If I choose to discontinue use of FollowMyHealth, I understand that a written request is necessary to cancel this agreement.**

I have received a copy of the **Follow My Health Patient Portal Terms and Conditions.**

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Signature of patient if over the age of 18 years Date

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Signature of Proxy Date

If you are representing the patient as a Legal Guardian or through Power of Attorney or Power of Attorney for HealthCare, please contact the St. Mary's/St. Joseph Legal Department at (989) 907-5607 to complete the patient portal registration process.
Technical questions can be directed to (989) 907-8401 Monday through Friday, 8 am to 4 pm.

Please present photo ID when presenting this form. Please return the completed form to a member of your provider's medical practice team.

For hospital access - Please return the completed form to Registration to be forwarded to Clinical Informatics.

FOR OFFICE USE ONLY
Identity of Patient/Legal Rep Verified By: ______________________
Patient's MRN ______________________