



1500 North Oakland • Bolivar, MO 65613 phone 417-328-6304 • fax 417-328-1110

## CMH Patient Portal Request Form

*In Accordance with Missouri Law, all requests for proxy access to minors between the ages of 13 and 18 will automatically be denied. Existing proxy access will automatically be revoked on their thirteenth birthday. Patients may revoke proxy access at any time.*

### ***Yes, I want my own CMH Patient Portal account***

**My Name** \_\_\_\_\_

**My Birth Date** \_\_\_\_\_

**My Signature** \_\_\_\_\_

**Email Address** \_\_\_\_\_

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### ***Yes, I want my parents to have access to my record***

**My Name** \_\_\_\_\_

**My Birth Date** \_\_\_\_\_

**My Signature** \_\_\_\_\_

.....

**Parent/Guardian Name** \_\_\_\_\_

**Parent/Guardian Date of Birth** \_\_\_\_\_

**Parent/Guardian Email** \_\_\_\_\_

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**Parent/Guardian Name** \_\_\_\_\_

**Parent/Guardian Date of Birth** \_\_\_\_\_

**Parent/Guardian Email** \_\_\_\_\_

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By signing above, I authorize the above named person(s) to review my electronic medical records maintained by Citizens Memorial Hospital District (CMH). I understand that this authorization allows the person named above to view my entire medical record of CMH via CMH Patient Portal.

#### **Understandings & Agreements of Requestor**

1. This authorization is voluntary.
2. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
3. I agree to waive all claims against the facility for the release of the requested information.
4. I understand that Citizens Memorial Healthcare cannot condition admission to the facility upon my providing this authorization.