The FollowMyHealth™ patient portal at Associated Foot and Ankle Specialists of Ohio (AFAS) is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize AFAS to email an invitation to create a portal account.

<table>
<tr><td rowspan="12">Purpose for Access:</td><td>PERSONAL ACCOUNT ACCESS: (photo ID required)</td></tr>
<tr><td>☐ I am 12-17 years of age and request access to my own medical record information</td></tr>
<tr><td>☐ I am 12-17 years of age and grant Read Only Access to my medical records to the authorized user listed below</td></tr>
<tr><td>☐ I am 12-17 years of age and grant Full Access to my medical records to the authorized user listed below</td></tr>
<tr><td>☐ I am 18 years or older and request access to my own medical record information</td></tr>
<tr><td>☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below</td></tr>
<tr><td>☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below</td></tr>
<tr><td>AUTHORIZED USER ACCESS: (copies of legal documents and photo ID required)</td></tr>
<tr><td>☐ I am 18 years or older and request Read Only Access to a medical record (indicate legal status below)</td></tr>
<tr><td>☐ I am 18 years or older and request Full Access to a patient medical record (indicate legal status below)</td></tr>
<tr><td>☐ I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient</td></tr>
<tr><td>☐ I am the parent of a Minor patient aged 11 or younger and possess their birth certificate</td></tr>
</table>

Patient Information *(please print)*:

Patient Name: ______________________________
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: ______________ Phone: ______________
MM/DD/YYYY

Email address where patient portal messages will be sent: ______________
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize AFAS to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to AFAS health care information:

Patient Signature: ______________ Date: ______________

Authorized User Name: ______________________________
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: ______________ Relationship to Patient: ______________
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: ______________
(PERSONAL EMAIL RECOMMENDED)

Address: ______________________________
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: ______________ Cell phone: ______________

Authorized User Signature: Date:

For Front Desk Use Only	
Photo ID & Copies of Legal Documents Verified By:	Date:
For Portal Use Only	
Patient Portal Invite sent by:	Date:
(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)	