MyRecord Patient Portal
REQUEST FORM

All fields must be completed. Please PRINT.

First Name:____Middle Initial:____________

Last Name:____

Date of Birth:____________________________ Contact Phone #:___________________________________

Email Address:____

Your Patient Portal login information and other Patient Portal communication will be sent to the email address you list above. Please be sure to list an active email account. You should also be sure that you are comfortable with this type of information being sent to the email address listed above.

By completing this form, I authorize that I am requesting access to the Cook Hospital MyRecord Patient Portal. I understand that upon completion of this form, I will receive login instructions to the Patient Portal at the email address identified above within three (3) business days.

I understand that the Patient Portal will include my private health information. I understand that once information is disclosed onto the Patient Portal, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that requesting access to the Cook Hospital MyRecord Patient Portal is voluntary, and that I need not sign this authorization to receive heath care treatment.

Signature:*____* ***Date:****____________________*

Return completed form to:
Cook Hospital & Care Center
Health Information Department
10 Fifth Street SE
Cook, MN 55723

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OFFICE USE ONLY:

Medical Record #:__________________________________ Entered into Meditech on the following date:_____________________

Completed by (name):____________________________________ Signature:____

Secy\Medical Records\MyRecord Patient Portal Request Form 3-1-17

PORTAL