For *Office use only*
Medical Record #_____

Thank you for requesting access to Essentia MyHealth. The information that you submitted on the website could not be matched with what we have on file. Please complete this form and return it to the address provided. *All sections must be completed. Please print clearly.*

Patient Name: *last,* _____ *first,* _____ *middle initial,* _____

Date of Birth: _____ Age: _____ Email Address: _____ Last four digits of SSN _____

Street Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Physician Name: _____ Your Mother's Maiden Name: _____

Insurance Membership ID: _____ Group #: _____ I do not have insurance ☐.

I allow Essentia Health 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 know in writing at any time. This change will become effective no later than the next business day after the date that Essentia Health receives my request and will not apply to information that has already been released before this effective date.
- Essentia Health 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 communications.

_____ _____/_____/_____
Signature of Patient Today's Date

Return completed form to:
Email: MyHealthSignUp@EssentiaHealth.org
Mail: Health Information Services – West Annex – HIS – 45
400 East Third Street, Duluth MN 55805
Fax: 218-786-6658

Essentia Health

MyHealth Access Self-Authorization