Asthma & Allergy Clinic of Marin & SF Inc.

Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Name _____ DOB _____

Patient Portal Account

I authorize the following person to access my Patient Health Record that is included with the Follow My Health Patient Portal located on our website (www.aasthma.com). This invitation will be sent within two weeks of completion of this form, please check your SPAM folder as it comes from a no reply address: noreply@followmyhealth.com

(Please complete all information if you would like access.)

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **CITY, STATE:** _____ **ZIP:** _____

PHONE: _____ **EMAIL ADDRESS:** _____

Patient or Authorized Representative Signature: _____ Date: _____

Patient or Authorized Representative Printed Name: _____

Form 7.2014