Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

Health Information Mgt - Patient Portal

Fax: 203-739-1542 Phone: 203-739-7218

Email: medicalrecords@wchn.org

Mail: Danbury Hospital, HIM Department,
24 Hospital Ave, Danbury, CT 06810

Patient Portal Access Request Form For Adult Authorized Representatives

PATIENT INFORMATION

Name: _____

Phone #: _____

Phone # (cell):_____

Date of Birth:_____

_____
Street

_____
Town/City State Zip

AUTHORIZED REPRESENTATIVE

I authorize the **Western Connecticut Health Network** to disclose online patient portal content **TO**:

Name: _____

Phone #: _____

Email Address: _____

INFORMATION REQUESTED

Format: X Secure Online Patient Portal Access - **Email address required above**

AUTHORIZATION

I hereby authorize the above individual to have access to my health records via the Western Connecticut Health Network online patient portal. I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as genetic, substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information. I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already taken in reliance on the authorization. The revocation letter should be sent to Health Information Management Department of Western Connecticut Health Network at Danbury Hospital, 24 Hospital Ave, Danbury, CT 06810. By signing below, I the proxy acknowledge and agree that I will comply with the Patient Portal Terms and Conditions.

X _____ _____
Signature of Patient **Today's Date**

X _____ _____
Signature of Authorized Representative **Relationship to Patient**

Send form to Health Information Management via any of the methods listed in the header.