Hammond-Henry HOSPITAL

REQUEST FOR ACCESS

Thank you in advance for your interest in Hammond-Henry Hospital's Patient Health Portal, a web-based patient portal that provides you with secure and convenient access to your health information. This request form must be completed and returned for access to the Patient Health Portal.

Name: (print) _____
(First Name) (Last Name)

Social Security Number: (last 4 digits only) ___ ___ ___ ___

Date of Birth: ____/____/_____
(mm / dd / yyyy)

Phone: (____)_____

Address: _____
(Mailing Address)

_____ _____ _____
(City) (State) (Zip)

Email: _____

A valid email address is required in order to utilize the Patient Health Portal. Please provide a current private email address and verify its accuracy. By providing an email address, you agree to have Hammond-Henry Hospital communicate with you regarding your patient portal via email. Absolutely no protected health information will be included in any email communications from Hammond-Henry Hospital.

By signing this form:

- I acknowledge that I am requesting access to my health information in the Patient Health Portal.
- I understand that access to the patient portal will not expire unless I notify Hammond-Henry Hospital in writing to discontinue portal access.
- I hereby affirm that I am the patient identified above. I understand that I may be subject to penalties under law for submitting false or misleading information in connection with this application to access the Patient Health Portal.

_____ _____
Signature Date

Once the form has been received and processed, you should receive a phone call detailing next steps in order to verify your identity. At that time you will be able to choose your username and password. Processing normally takes 72 business hours after our office receives the completed form. (F-452 5/23)

Mail or Fax to:

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Health Information Management (309) 944-9108 | Fax: (309) 944-9256 | www.hammondhenry.com