Patient Care Engagement
Methodist Hospital of Chicago

M.R. Number:_____

PATIENT CARE ENGAGEMENT PORTAL APPLICATION FOR OTHER'S RECORD

Thank you for your interest in the Patient Care Engagement Portal, an easy-to-use online tool that provides patients quick and secure online access to their health information at any time.

Instructions for Completing this Form:

To sign up for access to our Patient Care Engagement Portal for a patient who you are a legal guardian for, please complete this application and return it to Health Information Management of Methodist Hospital of Chicago. You will also be required to present valid photo identification along with proof of Guardianship, Surrogate or power of attorney for Health Care when submitting this form.

Your Information (All sections required):

Name: (first, middle initial, last)_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Patient's Information (Whom you are Requesting Access-All sections required):

Name: (first, middle initial, last)_____

Gender (Male/Female): _____ Phone Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Patient Care Engagement Portal Terms and Agreement:

- I understand that the Patient Care Engagement Portal is intended as a secure online source of confidential information. If I share the Patient Care Engagement Portal ID and password with another person, that person may be able to view the information.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that my activities with the Patient Care Engagement Portal may be tracked by computer audit and any entries I make may become part of the patient's medical record.
- I understand that Methodist Hospital of Chicago, as a convenience, shall provide me access to the Patient Care Engagement Portal and that Methodist Hospital of Chicago has reserved the right to deactivate access to the Patient Care Engagement at any time for any reason.
- By signing below, I acknowledge that I have read and fully understand this application and I agree to its terms.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Legally Responsible Person Date

For Health Information Management Internal Use:

Identity Verified By:_____ Date: _____

For Information Systems Internal Use:

Patient Care Engagement Portal Set-up Processed By:_____ Date: _____