



## Connect Another Adult Patient To myWMH Portal

### Adult Proxy Access- Patients 18 Years and Older Requirements and Procedures

Adult proxy access allows you to securely request others be given access to your medical information via the myWMH Patient Portal. In order to obtain access, you, the patient, and adult proxy must complete and sign the Adult Proxy Access Form. **Patients will be asked to present valid photo identification.** The proxy's access is terminated when you make a request to terminate their access, when the proxy requests WMH terminate their access or when you revoke your access myWMH Patient Portal.

Requirements for access to a patient's portal account:

- Adult proxy requests must be submitted by you, the patient.
- The patient and the proxy must both complete and sign the attached Adult Proxy Authorization Form.
- If proxy requestor is the Power of Attorney, appropriate documentation must be provided.
- If patient unable to complete this form, please contact the Wayne Memorial Hospital Medical Records Department at 570-253-8417
- Internet access and a working e-mail account that you check regularly
- Internet browser that meets the recommended minimum guidelines
- Accept the Terms and Conditions statement

#### PROCEDURES:

1. **Complete the Adult Proxy Access Form and the Patient Registration Form (if patient access not already established) to request others to have access to your myWMH Patient Portal account.**

All information must be entered as indicated in order to successfully process your request. If the information provided does not match our records, we will contact you. We will not send any information about your health via e-mail. We will use e-mail only to clarify your myWMH Patient Portal request. All the information you provide during the registration process is confidential and will be processed through secure internet servers.

2. **You will receive a myWMH Username and Password information via e-mail.** Upon validating your submission, a one time User Name, Password and login instructions will be emailed to you. Please allow three to five business days. This email link will be valid for 7 days once received.
3. **Activate your account.** - When you receive your user name and password, return to myWMH Patient Portal via the link provided in the email and complete the steps provided to activate your account.

**Medical Record Number (MRN):** Each patient has a unique MRN. Your Wayne Memorial Hospital Medical Record Number is the number preceded by the letter **M**. You do not have to include the zeros following the letter M (Example: M0000123456 is entered as M123456). Your medical record number can be found on most medical record information you have received from Wayne Memorial Hospital. It will be located on the patient label affixed to these documents. If you cannot locate your MRN, call the Medical Record Department for further instructions at 570-253-8417 Monday through Friday 7:00 am – 3:30 pm.

**Should Power of Attorney be revoked or limited you are responsible to report this to Wayne Memorial Hospital immediately.**



myWMH Patient Portal  
**Connect Another Adult Patient To myWMH Portal**  
Adult Proxy Access Form- Patients 18 Years and Older

**PATIENT'S INFORMATION**  
All Fields Are Required

**Patient's Name:** \_\_\_\_\_  
Last Name First Name Middle Initial

**Patient's DOB:** \_\_\_\_\_ **Patient's Gender:** Male:  Female:

**Patient's Medical Record Number:** \_\_\_\_\_ **Patients Last 4 digits of SS#:** \_\_\_\_\_

**Patient's Address:** \_\_\_\_\_  
Street Address City State Zip Code

**Patient's Phone Number:** \_\_\_\_\_

**Would you also like a myWMH Patient Portal Account:**

Yes  If yes please provide your e-mail address: \_\_\_\_\_  
PLEASE PRINT CLEARLY

No  Selecting no means all email notifications of activity in your account will be sent to your proxy's email.

**I authorize:** Wayne Memorial Hospital to release all myWMH Patient Portal information to the proxy listed below. Access does not expire without my request to revoke this authorization. **I have read and understood the guidelines regarding myWMH Patient Portal account and agree to allow proxy requestor listed below access to myWMH Patient Portal account information.**

\_\_\_\_\_  
PATIENT SIGNATURE (REQUIRED) Date

**PROXY'S INFORMATION**  
All Fields Are Required

**Proxy's Name:** \_\_\_\_\_  
Last Name First Name Middle Initial

**Proxy's DOB:** \_\_\_\_\_ **Proxy's Phone Number:** \_\_\_\_\_ **Proxy's Gender:** Male:  Female:

**Proxy's Address:** \_\_\_\_\_  
Street Address City State Zip Code

**Proxy Relationship to Patient:**

Parent/Legal Guardian:  Adult Child:  Spouse:  Power of Attorney:  (Please attach POA documentation to avoid delays)

Other:  If other, please explain: \_\_\_\_\_

**Proxy's Email Address** (Please Print Clearly): \_\_\_\_\_

Please provide a valid email address of the person who will be using **myWMH Portal**. Your one time login and password to myWMH will be provided to you in an email and will be active for 7 days.

**Do you (the proxy) currently have an active myWMH Portal Account?**

*A Social security number is required for authentication purpose. It will be stored securely in compliance with applicable laws.*

**YES**  If yes, please provide the Last 4 digits of your SS#: \_\_\_\_\_

**NO**  If no, please provide entire 9 digit SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**I have read and understood the requirements for accessing the above named patient's myWMH Patient Portal Account information and agree to abide by these requirements. I certify that all the information I have provided is correct. I hereby request access to the above named patient's myWMH Patient Portal account.**

\_\_\_\_\_  
ADULT PROXY SIGNATURE (REQUIRED) Date

**DO NOT MAIL THIS FORM. REQUESTOR MUST PRESENT TO WMH FOR ID VERIFICATION**

**For Wayne Memorial Hospital Use Only**

Person Name Receiving Request: \_\_\_\_\_  
PLEASE PRINT Title/Profession/Dept. \_\_\_\_\_

ID Verified (DATE): \_\_\_\_\_  Photo ID  Gov't. ID  Wrist Band  Other: \_\_\_\_\_

The undersigned witness affirms that valid photo identification was presented to me.

Person Receiving Request Signature: \_\_\_\_\_ Date: \_\_\_\_\_