MyFHN Patient Portal

Revocation of Access Form

We understand there may be reasons why you no longer wish to continue your access to MyFHN Patient Portal. Completion of the information below will allow for access to be removed. Please allow 3-5 business days upon receipt of this form for the access to be discontinued.

Instructions

Complete the request form in its entirety and submit to your provider's office.

Patient Information: Please print clearly.

Last Name _____ First Name _____ Initial _____

Social Security Number (last 4 digits) XXX-XX-_____ Date of Birth _____

Mailing Address _____ City _____

State _____ Zip _____

Phone Number _____

By signing below, I acknowledge that I hereby revoke access to MyFHN Patient Portal. Once access has been revoked, I will no longer be able to access health information through MyFHN Patient Portal. I understand that I must complete a new Request for Access form if I wish to regain access.

Patient Signature _____ Date _____

Parent/Guardian Printed Name (for patients under 12) _____ Date _____

Parent/Guardian Signature _____ Relationship to patient _____

FOR OFFICE USE ONLY

Applicable EMR Medical record Number _____

Received by: _____ Date _____ Time _____

Please forward this complete form to the MyFHN Patient Portal Coordinator

We're here, for you.
FHN