ThedaCare®

Authorization for Access to Online Health Information via MyThedaCare.org

Patient Name: _____ Date of Birth: _____ /_____ /_____

Address: _____ Social Security Number: _____-____-_____
(SSN used only to validate during access)

City: _____ State: _____ Zip: _____

I understand that access to MyThedaCare (online record) is for access to only my personal health information. **I understand that MyThedaCare is NOT to be used in an emergency.**

I understand it is my responsibility to maintain my password in a secure manner and to change it if I feel it has been compromised in any way.

I understand that I am accessing the following information about myself or my minor child:

- Basic laboratory results
- Communication between my provider and myself
- Ability to review, request, or schedule appointments
- Request renewals of prescriptions
- Summary information about my medical history

The reason for this disclosure is to play a more active role in my own health care. I understand that additional information may be made available to me through the MyThedaCare product, as ThedaCare advances this product.

I understand that my activities within MyThedaCare are tracked by computer audit and that entries I make can become part of my medical record.

I understand that by signing this agreement I am providing ThedaCare documentation of my authorization to access my own protected health information as described above. I understand written request must be made to cancel or revoke this authorization and any actions taken or accesses prior to that cancellation were authorized as part of the initial signature and date.

I understand my provider has the right to deactivate access to MyThedaCare for authorization or inappropriate actions on my part.

By signing below I am acknowledging that I understand the disclosure of my protected health information to me for my use.

Signature: _____ Date: _____ /_____ /_____

Print Name: _____

Current Primary Care Provider: _____

Email Address: _____