Clear Form

MY eHEALTH

PROXY REQUEST FORM

You may use this form to request access to view another person's medical record via MY eHEALTH. You will need to obtain the proper information, including a signature granting access, from the patient.

PART A: Enter your information below.

First Name | Middle Name | Last Name | Date of Birth

Address | City | State | Zip

Email Address | Telephone Number

PART B: Please list below the patient whose information you are requesting. You will need to complete all of the lines below, including obtaining the patient's signature. We will review all of this information and we may contact the patient to confirm permission. The patient may revoke proxy access at any time.

First Name | Middle Name | Last Name | Date of Birth

Relationship | Patient's Signature | Date

By signing above, I authorize the above named person to review portions of my electronic medical records maintained by Watertown Family Practice Associates, S.C. on the My eHealth portal.

Watertown Family Practice Associates, S.C.
127 Hospital Drive
Watertown, WI 53098
920-261-8500
www.watertownfamilypractice.com

My medical record number is_____