NorthLakes
COMMUNITY CLINIC

888.843.4551
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PATIENT INFORMATION

Please complete this form and return it to the receptionist. If you would like assistance, please ask.

Patient Personal Information Today's Date:___/___/____

Legal Name_____
(Last First Middle Initial)

Maiden or Previous Name_____Date of Birth (DOB):___/___/____

Name you prefer to be called (if different)_____Social Security Number (SSN)____-___-___

Mailing Address_____City_____St_____Zip_____

Home Phone_____Cell_____OK to leave message? Yes No

Email Address_____

Pronoun: ❒She/Her/Hers ❒He/Him/His ❒They/Them/Theirs Other:_____

Gender Identity: ❒Female ❒Male ❒Questioning ❒Non-Binary Other:_____

Gender Assigned at Birth:_____

Sexual Orientation: ❒Straight ❒Bisexual ❒Gay ❒Lesbian Other:_____

Marital Status: ❒Single ❒Married ❒Partnered ❒Divorced Other:_____

Race (check all that apply): ❒American Indian/Native Alaskan ❒Asian ❒Black/African American ❒White
❒Native Hawaiian ❒Other Pacific Islander

Ethnic Category (select one): ❒Hispanic/Latinx ❒Non-Hispanic/Latinx

Preferred Language:_____

Primary Care Provider:_____

Emergency Contact_____Phone_____Relationship_____

If patient is under 18 years of age, who is the parent or legal guardian?

Name_____Phone_____Relationship_____

INSURANCE INFORMATION

PRIMARY Medical Insurance Company (if uninsured, write "NONE")_____

Name of policy holder_____Relationship to patient: ❒Self ❒Parent ❒Spouse ❒Other

Policy holder's address (if different than above)_____

DOB___/___/____ Social Security #____-___-____ Insurance ID/Policy # _____Group #_____

SECONDARY or Dental Insurance Company (if applicable)_____

Name of policy holder _____Relationship to patient:❒Self ❒Parent ❒Spouse ❒Other

Policy holder's address (if different than above)_____

DOB ___/___/____ Social Security #____-___-____ Insurance ID/Policy # _____Group #_____

CONSENT FOR GENERAL CARE

I present myself for health care services at NorthLakes Community Clinic (NorthLakes) to be provided by authorized employees of the Clinic and clinical staff as may, in their professional judgment, be deemed necessary or beneficial. I realize that among those who attend to patients are NorthLakes health care staff and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my condition.

If a health care worker is exposed to my blood or other potentially infectious materials through any eye, mouth or other mucous membrane, non-intact skin or parenteral contact, I consent to a test of my blood to screen for the presence of Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV) or any antibody to the HIV virus, the cause of Acquired Immunodeficiency Syndrome (AIDS). I also consent to the release of reasonable, necessary portions of my medical record to assist NorthLakes in assessing potential risk related to such exposure. I authorize NorthLakes to release the test results to the exposed health care worker and any health care professional responsible for evaluating the exposed health care worker. I understand that I may have the right to consent to release of my test results to myself and/or my primary care physician.

AUTHORIZATION TO RELEASE INFORMATION

I authorize NorthLakes to disclose information from my medical/dental records (including transfer records) and/or my business office records to whom NorthLakes believes is responsible for the payment of my bill or is involved in my care and treatment. Should any portion of my records contain information regarding drug or alcohol abuse, consent is given to release such information necessary to obtain payment of my bill from insurance companies or other funding sources as named on the Requisition Records. I may revoke this consent at any future date upon written notification to NorthLakes; however, I understand NorthLakes may release information in good faith from the date I sign this consent until the date I may choose to revoke it. I authorize use of my medical/dental records and information for legitimate medical or scientific research purposes. Research procedures to not identify individuals by name or personal identifying characteristics.

OCCUPATIONAL HEALTH SERVICES

I consent to a physical examination/evaluation or testing to be performed by the staff of NorthLakes occupational health and any affiliated sites. I understand that I can expect an explanation of findings of the physical examination and any tests performed. No treatment is expected in connection with this exam/testing as it is for evaluation purposes only. I understand that my employer or insurer who is requesting this examination may be responsible for reimbursing NorthLakes or affiliated sites per company policy. Access to information from this evaluation/testing shall follow applicable statutes and regulations.

MEDICARE/MEDICAID PATIENTS

I certify the information I gave in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished me by NorthLakes, including physician services, and assign such benefits to NorthLakes. I authorize NorthLakes to release to Medicare/Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

FINANCIAL AGREEMENT

I agree to pay NorthLakes for all services provided to me by NorthLakes and others for whom NorthLakes collects bills at the regular rates. This includes services which, for any reason, are not paid by insurance, government programs or other third party sources. I understand that any self-pay portion of my clinic bill is due upon notification.

I authorize payments be made directly to NorthLakes of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided me. I understand professional (physician) services for radiology, lab and pathology are charged separately from my clinic bill and that I am financially responsible to those physicians for any charges for their professional services. If assignment of insurance benefits is accepted by such physicians, I authorize insurance payments be made directly to those physicians.

X_____ _____

Signature of Patient or Authorized Representative Date

X I acknowledge being offered the NorthLakes Notice of Privacy Practices_____ (Initials)

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PERMISSION TO DISCUSS

Patient Name: LAST FIRST MI Date of Birth

The staff at NorthLakes Community Clinic may discuss my health information with individuals that I have designated below. A staff member has fully explained what this consent means.

☐ **YES, I give permission to (PLEASE PRINT):**

Name Relationship

(Check all that apply) ☐ Make Appointments/Receive Appointment Reminders ☐ Pharmacy ☐ Billing Information ☐ Health Care Guidance ☐ Non-Confidential Test Results

Name Relationship

(Check all that apply) ☐ Make Appointments/Receive Appointment Reminders ☐ Pharmacy ☐ Billing Information ☐ Health Care Guidance ☐ Non-Confidential Test Results

Name Relationship

(Check all that apply) ☐ Make Appointments/Receive Appointment Reminders ☐ Pharmacy ☐ Billing Information ☐ Health Care Guidance ☐ Non-Confidential Test Results

☐ **NO, DO NOT** share my health information and/or medical records.

Patient Initials

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Dept. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand I am under no obligation to sign this form and that the person(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Revoke This Authorization** – I understand that the revocation will not apply to information that has already been released in response to this or any other previously received authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy. Unless otherwise revoked, this consent is effective for one year from the date of signature. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. I have had an opportunity to review and understand the content of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of minor ☐ Court appointed guardian/conservator ☐ POA for HealthCare

Patient Signature/Legal Rep: Date

Signature of Witness Title

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REQUIRED INFORMATION ABOUT YOUR HOUSEHOLD INCOME

This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee on services to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients. The *only* reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is very much appreciated.

Today's Date _____

Patient Name _____ **Date of Birth** _____

How many people are in your household? _____

(Please include yourself and anyone related by blood, marriage or adoption, and are legally financially responsible for each other)

Total Annual Household Income

☐ No Income

Using the table below, please indicate which column represents your TOTAL family/household gross income level (before anything is deducted) based on the number of persons included in your household. This includes any wages, alimony, disability, social security, retirement, unemployment, etc. **Check Below.**

Level - % of poverty (FPL) and Family Size:	☐ **<100%**	☐ **101%-150%**	☐ **151%-200%**	☐ **>200%**
1 Adult	< $ 12,880	$12,881- $19,320	$19,321- $25,760	$25,761
2- person Family	< $17,420	$17,421- $26,130	$26,131- $34,840	$34,841
3- person Family	< $21,960	$21,961- $32,940	$32,941- $43,920	$43,921
4- person Family	< $26,500	$26,501- $39,750	$39,751- $53,000	$53,001
5- person Family	< $31,040	$31,041- $46,560	$46,561- $62,080	$62,081
6-person Family	<$35,580	$35,581- $53,370	$53,371- $71,160	$71,161
7-person Family	<$40,120	$40,121- $60,180	$60,181- $80,240	$80,241
8-person Family	<$44,660	$44,661- $66,990	$66,991- $89,320	$89,321

If your household size is larger than 8, please see our Patient Services Representative for assistance in calculating your federal poverty level.

SLIDING FEE INFORMATION

We are able to offer a sliding fee scale on eligible services at NorthLakes to individuals or families with no income, low-income, or underinsured. Sliding fee calculations are based on the family/household size and annual gross income. Eligibility is based on your ability to pay according to Health Resource and Service Administration (HRSA) guidelines. Our Patient Financial Advocates are available to help if you need assistance applying for the sliding fee scale.

☐ **YES! I want to apply for the sliding fee scale.**

☐ **NO THANKS. I do not want to apply for the sliding fee scale.**

☐ **Currently on the sliding fee scale**

YOU MAY BE ELIGIBLE!

1. Even if you have insurance
2. Even if you don't have insurance
3. Even if you live out of state or live in WI seasonally
4. Even if you don't have many appointments
5. Even if you applied but were previously denied
6. Even if you do not have any income or POI
7. Even if you and your children have Medicaid/ MA/BadgerCare

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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Effective January 28, 2008

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION (AS A PATIENT OF THIS PRACTICE) MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

We may use and disclose your PHI in the following ways:

1. **Treatment:** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to our doctors and nurses—may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in the billing and collection efforts.
3. **Health Care Operations:** Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in the health care operations.
4. **Appointment Reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment Options:** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-related Benefits and Services:** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends:** Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information. A release to family or friend requires written consent.
8. **Disclosures Required by Law:** Our practice will use and disclose your PHI when required to do so by federal, state or local law.
9. **Fundraising:** Our practice may use your PHI for our own fundraising activities. You may opt out of this at anytime by following the instructions that will be included on any solicitation sent to you generated from using your PHI. If there are not instructions on that correspondence, your PHI was not used in creating or sending the materials.

Use and disclosure of your PHI in certain special circumstances: The following categories describe unique scenarios in which we may use or disclose your identifiable health information (PHI).

Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury, or disability,
- Notifying a person regarding a potential risk to spreading or contracting a disease or condition,
- Reporting reaction to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location of victim(s) of the crime, or the description, identity or location of the perpetrator).

Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military: Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

Inmates: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Worker's Compensation: Our practice may release your PHI for worker's compensation and similar programs.

You have the following rights regarding the PHI that we maintain about you:

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. In order to request a type of confidential communication, you must make a written request to our Site Manager specifying the requested method of contact or the locations where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make a written request to our Site Manager. Your request must describe in a clear and concise fashion:

- The information you want restricted,
- Whether you are requesting to limit our practice's use, disclosure, or both,
- To whom you want to limits to apply.

Inspection and Copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psycho-therapy notes. You must submit your request in writing to our Site Manager in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to emend information that is, in our opinion: (a) accurate and complete, (b) not part of the PHI kept by or for the practice, (c) not part of the PHI which you would be permitted to inspect and copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures: All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, operations, or fundraising. Use of your PHI as part of the routine patient care in our practice is not required to be documented—for example, the doctor sharing information with the nurse, or the billing department using your information to file your insurance clain. In order to obtain an "accounting of disclosures", you must submit your request in writing to our Site Manager. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before January 28, 2008. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-months period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Site Manager. Complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy policies, please contact our Chief Executive Officer.

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INTERNAL RELEASE OF INFORMATION

Today's Date:_____

Patient Name: _____ Maiden Name: _____

Date of Birth: _____

All services and care team members that are a part of your health care plan will have access to your Protected Health Information in order for the team to better serve your health care needs. You have the right to have any area of your services excluded.

As a patient of NorthLakes Community Clinic, you are automatically included in *Care Everywhere. Care Everywhere* is an information-sharing platform that allows for care management, continuity and coordination of care. Your team members at any *Care Everywhere*-participating clinic or hospital will have access to your electronic health records. If you are seen in an Emergency Room or Urgent Care, for continuity and coordination of care, these outside medical facilities will have access to your electronic health records.

To better meet the needs of your family unit, all services and care team members that are treating minor siblings, children and parents, or, children and guardians, will have access to your care and treatment plan for the purposes of care management, continuity and coordination of care.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosures. I understand that the information in my medical records may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychiatric management, behavioral and mental health services, and treatment for alcohol and drug use through NorthLakes general provision of health care. NorthLakes employs certain staff members who provide substance use disorder diagnoses, treatment, or referral for treatment through NorthLakes Recovery Program. I understand records created as part of this program are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and/or HIPAA 45 CFR, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. In addition, I understand that this consent form does not apply to my records that do not identify me, directly or indirectly, as an individual participating in a program for substance use disorders. I understant that I have the right to receive a copy of the health information I have authorized to be used or disclosed by this authorized form as required ss. DHS 92.05,92.06, and 94.05. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I can do so in writing or verbally. However, it is highly recommended to send a written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____

Date Signature of ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Authorized Legal Representative

_____

Date Signature of ☐ Patient ☐ Parent/Guardian (*If patient is 14+years of age, both patient and parent/guardian must sign)*

This authorization will expire one year from the above date, unless listed here: _____

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Teen Access to Their MyChart Record

Thank you for your interest in signing up for MyChart. MyChart is an easy-to-use Internet tool that provides you quick and secure on-line access to your electronic medical record information.

Instructions for Completing this Form:
To sign up for access to your electronic medical record information in MyChart, please complete this Sign-Up Form and return it to any staff member.

Name (last, first, middle initial) _____Date of Birth: ___/___/____
Email Address: _____@ _____

MyChart Agreement:

- I understand that MyChart is as a secure on-line way for me to see my confidential medical information.
- I understand that if I share my MyChart ID and password with another person, that person will be able to see my confidential medical information. I understand that MyChart might include information about my doctor visits that I don't want other people to know about.
- I agree that it is my responsibility to make up a confidential password, and to keep my password safe. I agree to change my password if I think that someone else has found out what my password is, and I don't want them to see my medical information.
- I understand that MyChart contains some medical information from my electronic medical record, and that MyChart does not include all of the information in my electronic medical record.
- I understand that when I look at information in MyChart, or add information in MyChart, it will be tracked in my electronic record.
- I understand that information that I type into MyChart may become part of my medical record.
- I understand that access to MyChart is provided as a convenience to me and that NorthLakes has the right to turn off my access to MyChart at any time, and for any reason.
- I understand that use of MyChart is voluntary, and I am not required to use MyChart. NorthLakes will not condition my treatment on my usage of MyChart.
- I understand that I am not required to let anyone else look at my MyChart record.
- I understand that if I have a medical emergency I should call 9-1-1 immediately and not report urgent matters using MyChart.
- I understand that I may discontinue my use of MyChart by contacting NorthLakes.
- By signing below, I understand that I have read and understand this MyChart Sign-Up Form and that I agree to its terms.

_____ _____

Your Signature Date