Westchester Institute for Human Development

WIHD PATIENT PORTAL REQUEST FORM

WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD) offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians through a Patient Portal.

To have access to the WIHD Patient Portal, please print all information clearly:

Patient's Name: _____ **Date of Birth**: _____

Who is requesting Portal Access? (Select all that apply):

☐ **Patient: Email Address** _____

☐ **Guardian or Representative: Email Address** _____

☐ **Agency: Email Address (preferably generic Agency email)** _____

AGENCY INFORMATION (if applicable)

Name/Organization:_____ Phone Number: _____

Address: _____

Agency Contact Person: _____ Agency Contact Email: _____

- *This Agency/Organization can request patient portal access for the agency staff providing care for the patient mentioned above*
- *Please note that the agency has the responsibility to let WIHD know when the personnel who has access to the patient portal has changed or not employed by the agency. You can let WIHD know about changes in staff who has access to the patient portal by sending an email to pportal@wihd.org*

By signing and dating this form, I am authorizing WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD) to create a patient portal Logon ID and password for the patient listed above. By signing this form, I also understand that records accessed by the proxy/caregiver/agency could be re-disclosed without my knowledge. I further understand that information in the patient portal may include treatment and testing regarding drug/alcohol abuse, mental health, HIV status, sexually transmitted disease and diagnosis, genetic testing and reproductive medicine.

Signature: _____ **Date**: _____

Print Name of Patient of Personal Representative: _____

Description of Personal Representative's Authority: _____

* If an agency representative signs this form, please include an agreement indicating permission for the agency to provide health services and authorizing the agency to receive, review, and release medical information
* You may at any time revoke the proxy access by contacting WIHD at 914-493-8148 and filling out the proxy revocation form. Your designated proxy will have access to your patient portal records until that time.
* Legal Guardians are required to advise WIHD immediately if there is a change in authority

- We need you to make sure we have the correct email address and you MUST inform us if it ever changes.
- If you forget your password please use the "forgot password" option on the portal.
- Patient Portal website is https://emr.wihd.org/PatientPortal/CurePatientHome.aspx?wihd
- **Please bring this form to your next appointment, fax this form to (914) 493-8755, or send it by e-mail to pportal@wihd.org**

For WIHD Use ONLY

☐ Consent to Disclose PHI or Agreement indicating permission for Agency to provide health services on file

Dev 3/2019, Rev 4/2019, Rev 10/19