Penn Medicine
Lancaster General Health

Patient Name: _____

MRN: _____

Date of Birth: _____

Complete above information or attach patient label to each page.

Consent to Signup Form (Age 18 & Over)

Thank you for your interest in MyLGHealth. MyLGHealth is a secure patient portal that allows you to access parts of your medical record online.

MyLGHealth Terms and Agreement

- **I understand that MyLGHealth is NOT to be used in an emergency situation.**
- I understand that MyLGHealth is intended as a secure online source of confidential medical information. If I share my MyLGHealth ID and password with another person, that person may be able to view my or my child's health information, and information about someone who has authorized me as a MyLGHealth Proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyLGHealth contains select medical information from a patient's medical record and that MyLGHealth does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's practice.
- I understand that my activities within MyLGHealth may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyLGHealth is provided by Lancaster General Health as a convenience to its patients and that Lancaster General Health has the right to deactivate access to MyLGHealth at any time for any reason. I understand that use of MyLGHealth is voluntary and I am not required to use MyLGHealth or to authorize a MyLGHealth Proxy.

This form must be completed in the presence of a Lancaster General Health staff member who is not the patient or proxy

I hereby authorize *(Proxy full name)* _____ to access my protected health information using MyLGHealth, and have the ability to act on my behalf via MyLGHealth, as indicated in the "Adult Proxy Form (Adult to Adult)" document. I may revoke this proxy access any time I wish, by means of my personal MyLGHealth Account.

X _____ _____

Patient's Signature (granting access) Date Time

_____

Patient's Printed Name

I have read and understand the requirements and procedures for accessing a patient's medical record information online as provided above and agree to act as a Proxy for the above mentioned patient.

X _____ _____

Proxy's Signature (requesting access) Date Time

_____

Proxy's Printed Name

X _____ _____

LG Health Employee Witness Signature (cannot be patient or proxy) Date Time

_____

LG Health Employee Witness Printed Name

Penn Medicine
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Patient Name: _____

MRN: _____

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Complete above information or attach patient label to each page.

Consent to Signup Form (Age 18 & Over)

Please fill out all of the required information below in order to sign up for a MyLGHealth account. Once we have received this form we will send your access code via the United States Postal Service. Please allow ten business days from mailing this form for processing your request of an access code.

PLEASE PRINT ALL INFORMATION CLEARLY:

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____)_____ Email: _____

Date of Birth: _____

Primary Doctor's Office: _____

Primary Care Physician: _____

Completed forms may be sent by the following methods:

1. **Scan and e-mail to:** LGLegalForms@LGHealth.org
2. **Fax to:** 717-544-8884
3. **Mail to:** Health Information Management
   Attn: Document Imaging
   555 North Duke Street
   PO Box 3555
   Lancaster PA 17604-3555

Office Use Only

☐ **Access Code Letter Generated**

☐ **Form Scanned**