Health Information Management
(225) 924-8127

MyHealth.Womans.Org
Patient Portal Registration Form

Please PRINT clearly.

Patient Information

LAST Name: ____________________ **FIRST Name:** ____________________ **MIDDLE Initial:** ______

Address: ____

City: ____________________ **State:** ____________ **Zip Code:** ____________

Date of Birth: ______/______/______ **Gender: Female** ☐ **Male** ☐ **Physician:** ____________________

Home Phone: (______)____________ **Cell Phone: (______)**____________ **Work Phone: (______)** ____________

Personal Email: ____

- I understand in 5-7 business days I will receive an email from **Woman's Hospital [noreply@womans.org].** This email will provide instructions for setting up my username and password for MyHealth.Womans.org patient portal.
- I understand I must agree to the Terms & Conditions listed in the online MyHealth.Womans.org user agreement.
- I understand 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 the MyHealth.Womans.org patient portal is intended as an online source of confidential medical information. If I share my MyHealth.Womans.org patient portal user ID and password with another person, that person will be able to view my health information.
- I understand my use of the MyHealth.Womans.org patient portal is provided as a convenience. Woman's Hospital makes no guarantees the patient portal will be available 24 hours a day, 7 days a week. The patient portal may be unavailable without prior notice. Woman's Hospital has the right to deactivate access.
- I understand MyHealth.womans.org contains limited health information and does not contain all information contained in my medical records. Health information is not immediately available on MyHealth.womans.org. I can request a copy of my medical information from the Woman's Hospital Health Information Management Department.
- I understand I must present a pictured ID and this consent must be filled out completely, signed, and dated in order to be considered valid.

Patient Signature: ________________________________ **Date:** ____________

Return forms to the Health Information Management Department.

HIM Use Only

Date received: ____________ **Date completed:** ____________ **Completed by:** ____________________

MR#: ____________ **ID Validated:** ☐ **Employee Badge** ☐ **Driver's License** ☐ **Other** ____________

Initial 11/2015 Revised 3/2020