# Sullivan County Community Hospital
# My SCCH Health Record Portal

## REQUEST FOR ACCESS FORM

Thank you in advance for your interest in Sullivan County Community Hospital's **My SCCH Health Record Portal**, a web-based patient portal that provides you with secure and convenient access to your health information. This request form must be completed and returned for access to My SCCH Health Record Portal.

**YOUR INFORMATION:**

First Name ____________________________M.I._________ Last Name____________________________

Social Security Number (last 4 digits only) ___________________

Date of Birth (Mm/dd/yyyy) __________________________

Telephone (        ) _________________________

Mailing Address______________________________________________________

City___________________________ State______________________

Zip Code___________________

Email_____________________________________________

A valid email address is required in order to utilize **My SCCH Health Record Portal**. Please provide a current, personal private/non-shared email address that only you have access to and verify its accuracy. By providing an email address, you agree to have SCCH communicate with you regarding **My SCCH Health Record Portal** via email. Absolutely no protected health information will be included in any email communications from SCCH.

□ By checking this box, I acknowledge that I am requesting access to my health information in **My SCCH Health Portal**. I understand that access to patient portal will not expire unless I notify SCCH in writing to discontinue portal access. I understand that the information in my health record may include information related to sexually transmitted disease, and acquired immunodeficiency syndrome/human immunodeficiency virus. It may also include information related to behavioral or mental health services and treatment for alcohol/drug abuse if present in my record.
□ I hereby affirm that I am the patient identified above. I understand that I may be subject to penalties under law for submitting false or misleading information in connection with this application to access the **My SCCH Health Portal**.

Signature _________________________________________________________