## **MyFHN Patient Portal**

## **Revocation of Access Form**

We understand there may be reasons why you no longer wish to continue your access to MyFHN Patient Portal. Completion of the information below will allow for access to be removed. Please allow 3-5 business days upon receipt of this form for the access to be discontinued.

## **Instructions**

Complete the request form in its entirety and submit to your provider's office.

| Last Name  | First Name                              | Initial |
|--|---|---------|
| Social Security Number (last 4 digits) XXX-XX  | Date of Birth                           |         |
| Mailing Address  | City                                    |         |
| State  | Zip                                     |         |
| Phone Number   |   |         |
| Request for Access form if I wish to regain access.  |   | •       |
|  | Б.                                      |         |
|  |   |         |
| Parent/Guardian Printed Name (for patients under 12)   | Date                                    | e       |
| Patient Signature  Parent/Guardian Printed Name (for patients under 12)  Parent/Guardian Signature | Date                                    | e       |
| Parent/Guardian Printed Name (for patients under 12)<br>Parent/Guardian Signature                  | Pate                                    |         |
| Parent/Guardian Printed Name (for patients under 12)   | Relationship to patient  FFICE USE ONLY | e       |
| Parent/Guardian Printed Name (for patients under 12)  Parent/Guardian Signature  FOR O             | Relationship to patient  FFICE USE ONLY |         |

