Wyoming Health
Medical Group LLC
Wyoming Medical Center

MyWMC Patient Portal Terms and Conditions

Please fill out one form per patient

Patient Name _____
(please print) Last First Middle

Patient Date of Birth _____/_____/_____ I certify that I, _____ am the:
☐ Patient ☐ Parent ☐ Legal Representative ☐ Authorized Proxy, with legal/authorized proxy rights to the record of _____.
(Patient Name)

My Address: _____
Street City/State Zip

Phone #: _____ Last 4 of my SS#: _____ Email address: _____
(Work email is not recommended)

I would like to register for the MyWMC patient portal, which will allow me access to:

- Communicate securely with participating health care team members
- Request, review, and cancel appointments
- View lab results, discharge summaries, and educational materials
- Request renewals of prescriptions
- View medical information including records that may be of a sensitive nature.
- View lab results, discharge summaries, and educational materials.

I understand that MyWMC Patient Portal is to be used only for routine matters. If I have an urgent issue or need a response quickly I will call my/my child's/my proxy's health care team, go to a nearby emergency department or urgent care center, or call 911. I also understand that messages I send to my/my child's/my proxy's health care team will become part of the permanent medical record. I agree that all entries will be truthful and relevant to my/my child's/my proxy's health issues.

I understand that the initial invitation to create an account will be sent to the above email address and that notifications will be sent to that email address to keep me informed of incoming communications on MyWMC Patient Portal. I agree to update MyWMC Patient Portal with any changes in my email address. I also understand that I must inform WMC's Chief Privacy Officer should a court document preclude me from viewing my child's/my proxy's records.

I understand that I will choose a unique user ID and password. I agree to keep the password confidential and not share it with anyone because it allows access to personal health information. If I choose to discontinue use of MyWMC Patient Portal, I understand that a written request is necessary to cancel this agreement. I acknowledge that access to my minor child's record will expire on the day prior to their eighteenth (18) birthday and my access as proxy may be revoked at any time by the patient. Additionally, I understand that WMC may cancel my access at any time.

I understand that authorization for me/my child/my proxy may be revoked by sending or faxing a written notice to the: Chief Privacy Officer, 1233 E Second St., Casper, WY 82601 or fax (307) 233-8133, stating intent to revoke this authorization.

I have been offered a copy of the MyWMC Patient Portal Terms and Conditions.

SIGNATURE _____ DATE _____
Patient/Parent/Patient's Legal Representative/Authorized Proxy