**Patient Portal Proxy Access Request and Authorization Form**

**PATIENT INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits of SS# \_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

City, State, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZING ACCESS FOR (Check box that indicates patient status)**

* Adolescent (13 through 17 years of age. Access is permitted only with written consent of the child and is valid until Revoked by the patient in writing or until age 18.)
* Adult (18 and older)

**PATIENT’S AUTHORIZATION**

I authorize the person named below (“my proxy”) to have access to my patient portal account. Information in my patient portal will be available to my proxy upon completion of this Authorization, which may include information related to mental health treatment, sexually transmitted diseases, HIV/AIDS, genetic testing, and records related to alcohol and substance abuse. My patient portal may also include medical information from multiple sources including records created by other providers I have seen within this practice or any other practice as care providers often share medical records and information for treatment. I understand that if there is information that I do not want my proxy to see, then I should not sign this Authorization.

 I understand that once information has been disclosed to my proxy, it may potentially be re-disclosed by my proxy and the disclosed information may not be protected by state or federal privacy laws. I agree that my health care provider and its agents are not responsible for my proxy’s use or publication of information access through my patient portal. I understand that authorizing my proxy to have access to my patient portal is voluntary. I understand that I do not need to sign this Authorization to assure treatment. I understand that I may revoke this Authorization at any time and my proxy’s access to my patient portal will be terminated upon written request. I understand that I am entitled to a copy of this Authorization.

 Date: \_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROXY INFORMATION (Person who will be receiving access to my health information)**

Proxy’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Proxy’s Relationship to the Patient: (Check one)**

* Parent
* Legal Guardian
* Power of Attorney for Health Care
* Other

If you are the Legal Guardian or Power of Attorney for Health Care you must provide a copy of the guardianship letters of office or executive Power of Attorney for Health Care verifying your authority to have access to the patient’s medical information.

**PROXY SIGNATURE**

By signing below, I acknowledge and agree that I will use my proxy patient portal account to access the patient’s portal information and that I will comply with all usage requirements and terms and conditions of use for the patient portal, including but not limited to my agreement not to share login or password information, to establish a confidential login name and password, to maintain all data in a secure manner, and to ensure that my email address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me regarding this patient. I acknowledge that access to the patient portal is provided as a convenience to patients and their authorized representatives and may be revoked at any time for any reason.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Proxy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_