CMH Community Memorial Hospital

AUTHORIZATION FOR ADULT PROXY ACCESS TO PATIENT PORTAL

Patient Information *(Please print)*

Patient Name: _____(first) ____(MI)_____(last)

Date of Birth:____ /____ /_____ Phone Number (_____) - _____ - _____ Sex: ☐ Male ☐ Female

Email Address: _____

Street Address:_____ City:_____State:____ Zip Code: _____

Proxy Information *(Please print)*

I authorize the following individual to participate in Community Memorial Hospital's Patient Portal as my proxy.

Proxy's Name: _____(first) ____(MI)_____(last)

Date of Birth:____ /____ /_____ Phone Number (_____) - _____ - _____ Sex: ☐ Male ☐ Female

Email Address: _____

Street Address:_____ City:_____ State:____ Zip Code: _____

Proxy Relationship to Patient: _____

I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Community Memorial Hospital continues to implement this product.

By signing this authorization, I am requesting Community Memorial Hospital to give access to my proxy to utilize the patient portal. I understand that Community Memorial Hospital will require my proxy to sign an acknowledgment and agree to the terms and conditions for use of the patient portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Patient Acknowledgment

_____ _____
Signature of Patient Date

Proxy Acknowledgment

_____ _____
Signature of Proxy Date

CMH Health Information Services Dept USE ONLY Medical Record Number:_____

Identification of patient verified? (circle one**) Y / N** Method (circle one) Photo ID / Compare signatures / Other :_____
Identification of proxy verified? (circle one**) Y / N** Method (circle one) Photo ID / Compare signatures / Other :_____

Entered in Meditech: _____ Completed By: _____
Date Staff Signature/Initials