CMH Community Memorial Hospital

REMOVAL OF 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 to **remove** Proxy status for accessing my Patient Portal information for the following individual:

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: _____

By signing below, I am authorizing the removal of Proxy access for the individual stated above. I understand that this results in the termination of Patient Portal Proxy access to my account only. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon prior Proxy authorization. I understand that Community Memorial Hospital has one business day (not including holidays) to execute this request once the request is received and is correctly completed.

Patient Acknowledgment

_____ _____

Signature of Patient Date

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

Date and time request received:_____

Date and time request fulfilled/removed in MEDITECH:_____

Completed By:_____

Staff Signature /Initials