CMH Community Memorial Hospital

REMOVAL OF PROXY ACCESS TO PATIENT PORTAL

Patient Information *(please print)*

Name on record: _____

Date of birth: _____ Phone #: _____ Sex: M / F / Other _____

Address: _____

City: _____ State: _____ Zip code: _____

Email address: _____

Proxy Information *(please print)*

I authorize to **remove** Proxy status for accessing my Patient Portal information for the following individual:

Proxy's name: _____

Date of birth: _____ Phone #: _____ Sex: M / F / Other : _____

Address: _____

City: _____ State: _____ Zip code: _____

Email address: _____ Proxy relationship to patient: _____

Remove access from these portals (check all that apply):

☐ CMH Hospital ☐ CMH Specialty Clinic ☐ CMH Raiter Family Clinic

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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 CMH has one business day (not including holidays) to execute this request once the request is received and is correctly completed.

Acknowledgement

_____ _____

Patient Signature Date

If you need to mail in this form, please mail to:
Health Information Management - Community Memorial Hospital - 512 Skyline Blvd Cloquet, MN 55720

CMH USE ONLY:

Medical Record Number: _____

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

Entered in:

☐ Meditech (Date) _____ Completed by (staff name/signature) _____
☐ Sp. eCW (Date) _____ Completed by (staff name/signature) _____
☐ RC eCW (Date) _____ Completed by (staff name/signature) _____