CMH Raiter Family Clinic
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: M / F / Other _____

Email Address: _____

Street Address:_____City:_____State:_____Zip Code: _____

Proxy Information *(Please print)*

I authorize the following individual to participate in CMH Raiter Family Clinic'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: _____

Type of access: (Please check one)

☐ Complete Access

☐ Restricted Access (Clinic portals only)

Allow access to these portals (check all that apply):

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

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 CMH Raiter Family Clinic continues to implement this product.

By signing this authorization, I am requesting CMH Raiter Family Clinic to give access to my proxy to utilize the patient portal. I understand that CMH Raiter Family Clinic 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.

_____ _____
Signature of Patient Date

_____ _____
Signature of Proxy Date

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) _____