Patient Portal Proxy Authorization

Please complete this form if you are an adult patient at least 13 years of age and want to give another adult access or grant proxy access to your patient portal account. Also complete this form if you are a legal guardian or have a durable power of attorney for healthcare, of an adult patient and you are requesting proxy access on behalf of that patient. You will be required to provide documentation to show you have legal rights to request this proxy access. The patient portal contains limited medical information.

Patient Information (Please Print):

Last Name: ___________________________ First Name: ___________________________

Date of Birth _________________ Email address: ________________________________

Proxy Information (Please Print):

(Person you are granting permission to access your patient portal account)

Last Name: ___________________________ First Name: ___________________________

Date of Birth: _________________ Email address: ________________________________

Street Address: ____

City: ________________________________ State: ___________ Zip Code: ____________

Primary Phone: ______________________ Secondary Phone: ______________________

Relationship to Patient:

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other ______________________

Is there a court or restraining order that limits your access to this patient's health information? ☐ Yes ☐ No

Purpose for Access:

☐ Legal Guardian ☐ Power of Attorney ☐ Continuity of Care

I understand that the information to be released may include information relating to the diagnosis and/ or treatement of mental illness, alcohol/drug abuse, sexually transmitted infections including HIV or AIDS, test results, and developmental disabilities.

____ ____________________

Patient Signature Today's Date

____ ____________________

Representative Signature Today's Date