



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 treatment 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