CONSENT FOR AUTHORIZED PERSONAL REPRESENTATIVE'S ACCESS TO THE PATIENT'S PORTAL ACCOUNT (PATIENTS AGE 12 YEARS AND UP)

Patient's Full Name: _____ Patient's DOB: _____

Proxy's Relationship to Patient:_____

Proxy's Full Name: _____

Proxy's Email Address: _____

Proxy's Phone Number: _____

Proxy's Full Address: _____

This consent expires at age 18. I, (patient / authorized personal representative), request that the above-named individual be granted proxy access to the patient's patient portal account. I understand that this person will be able to view portions of the medical record (including sensitive information as cancer, pregnancy or infectious disease related information). These include diagnoses, test results, medications, immunizations, allergies, past and future appointments, clinical notes and messages. Proxies will not be able to view messages that were flagged as sensitive and not sent to or by them. I understand that I may request that the access of the above-named individual to the patient portal account be disabled at any time by contacting the clinic or hospital admitting staff or by calling the HelpDesk.

Date: _____ Time _____

Patient Signature: _____ Full Name Patient: _____ Date: _____ Time: _____

Proxy Signature: _____ Full Name Proxy: _____

Relationship to Patient: _____ Date: _____ Time: _____

Witness Signature: _____ Witness Full Name:_____ Date: _____ Time: _____

Patients younger than 12 years of age will not be able to access their patient portal account