CHRISTIE CLINIC

Patient Portal Proxy Access Request and Authorization Form

PATIENT'S INFORMATION

All fields are required.

Patient's Name: _____ Medical Record Number #_____

Address: _____ Last 4 digits of SS# _____ DOB: _____

City, State, ZIP: _____ Telephone No: _____

AUTHORIZING ACCESS FOR (check box that indicates patient status)

☐ **Child** (Birth through 11 years of age. Access will be automatically terminated when the child reaches the age of 12.)
☐ **Adolescent** (12 through 17 years of age. Access is permitted only with written consent of the child and is valid until Revoked by the patient in writing or until the patient turns age 18.)
☐ **Adult** (18 and older.)

PATIENT'S AUTHORIZATION

I authorize the person named below ("my proxy") to have access to my patient portal account. Information in my patient portal will be available to my proxy upon completion of this Authorization, which may include information related to mental health treatment, sexually transmitted diseases, HIV/AIDS, genetic testing, and records related to alcohol and substance abuse. I further understand that my patient portal may include medical information from multiple sources including records created by **any** provider I have seen as care providers in unrelated groups often share medical records and information for treatment. For example, if I sought treatment from a provider in another state, this information may be shared with my local provider and be available in my patient portal. I **understand that if there is information that I do not want my proxy to see, then I should not sign this Authorization.**

I understand that once information has been disclosed to my proxy, it may potentially be re-disclosed by my proxy and the disclosed information may not be protected by state or federal privacy laws. I agree that my health care provider and its agents are not responsible for my proxy's use or publication of information access through my patient portal. I understand that authorizing my proxy to have access to my patient portal is voluntary. I understand that I do not need to sign this Authorization to assure treatment.

I understand that I may revoke this Authorization at any time and my proxy's access to my patient portal will be terminated. I understand that I must do so in writing and give my revocation to the Health Information Services Department. For adolescents (ages 12-17), the Authorization is valid until my 18th birthday unless I submit a written request to revoke proxy access to the Health Information Services Department. I understand that a revocation is not effective for uses and disclosures of my medical information that have already been made or other actions that have been taken in reliance on this Authorization or as required by law. I understand that I am entitled to a copy of this Authorization.

I understand that If I opt out of receiving any notifications/alerts to my patient portal account, the proxy named below will continue to receive such notifications including but not limited to emails and text messages.

_____ _____

Date Signature of Patient or Legal Representative

PROXY INFORMATION (person who will be receiving access to my health information) All fields are required.

Proxy's Name: _____ DOB: _____

Address: _____

City, State, ZIP: _____

Telephone No.: _____ Email: _____

Social Security Number: _____ *(Please note that the social security number is required for authentication purposes and will be stored securely in compliance with applicable law.)*

Proxy's Relationship to the Patient: (Circle one)

Parent **Legal Guardian** **Power of Attorney for Health Care** **Other**

If you are the Legal Guardian or Power of Attorney for Health Care you must provide a copy of the guardianship letters of office or executive Power of Attorney for Health Care verifying your authority to have access to the patient's medical information.

PROXY SIGNATURE

By signing below, I acknowledge and agree that I will use my own patient portal account to access the patient's portal information and that I will comply with all usage requirements and terms and conditions of use for the patient portal, including but not limited to my agreement not to share login or password information, to establish a confidential login name and password, to maintain all data in a secure manner, and to ensure that my email address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me regarding this patient. I acknowledge that access to the patient portal is provided as a convenience to patients and their authorized representatives and may be revoked at any time for any reason.

_____ _____

Date Signature of Proxy

_____

Relationship to the Patient
(Parent, Legal Guardian, Power of Attorney for Health Care, etc.)

Once completed please route to **HIS** for scanning. Revised 9/2019