Med Center Health
The Medical Center
Bowling Green • Scottsville • Franklin • Caverna • Albany

Med Center Health
Commonwealth Regional Specialty Hospital

Authorization for Proxy Access to Patient Portal

Patient Name: _____

Email Address: _____
(Please supply the email address of the person who will be using the patient portal)

I authorize the following individual to participate in Med Center Health's Patient Portal as my proxy.

(Please print)
Name: _____ Date of Birth: _____

Address: _____

Proxy Phone Number: _____

I understand my proxy will have the same access and privileges I have for the Patient Portal. I understand 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 additional information may be made available to my proxy through the patient portal as Med Center Health continue to implement this product.

By signing this authorization, I am requesting Med Center Health to give access to my proxy to utilize the patient portal. I understand Med Center Health will require my proxy to sign an acknowledgment and agree to the policies and procedures for use of the patient portal.

This authorization is valid until revoked by me. I understand a written request is necessary to revoke or cancel this authorization. However, I understand 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.

Patient Acknowledgment _____ _____
Signature of Patient Date

Proxy Acknowledgment _____ _____
Signature of Proxy Date

Revocation Acknowledgment _____ _____
Signature of Patient Date

___Photo ID of patient attached _____Staff initials
___Photo ID of proxy attached _____Date portal updated

_____Date revocation implemented _____Staff initials