PATIENT PORTAL AUTHORIZATION FOR GRANTING PROXY ACCESS

In addition to Patients registering themselves, Patients may request proxy access to their Patient Portals by completing the below registration form. **Patients who permit proxy access of their records do so at their own risk.**

Proxies will be given their own User ID and Password to access the Patient Portal for the Patient who requested the proxy access.

It is your responsibility to terminate proxy access if you no longer with for your proxy to have access to your health care information through the Patient Portal. Proxy access may be terminated at any time, without proxy consent.

Patient Name:_____ **Date of Birth:**_____

I authorize Schuylkill Medical Centers to grant the following individual access to my confidential health information through the Patient Portal for this encounter.

Proxy Name: _____

Relationship to Patient:_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Email Address Unique to Proxy: _____

I understand that my proxy will have the same access and privileges that I have to my Patient Portal. Patients who permit proxy access of their records do so at their own risk. My proxy will be able to view the portions of my record that I am able to view. This includes HIV/AIDS, mental health and/or drug and alcohol abuse and treatment information about me.

This authorization is valid until revoked by me. I understand that a written request is necessary to cancel or revoke this authorization, as described in the Hospital's Notice of Privacy Practices. However, I understand that 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 privacy laws.

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization and I am authorizing Schuylkill Medical Center to grant the proxy I identified herein access to my confidential medical records via the Patient Portal.
- I understand that Schuylkill Medical Center is not responsible for the proxy's inappropriate use or publication of the information they gain access to through the Patient Portal.

Signature of Patient: _____ **Date:**_____

Signature of Personal Representative: _____ **Date:** _____

If signed by the individual's personal representative, describe the legal authority to act on behalf of the individual:

_____

Legal authority of representative verified by: _____

Staff is available to answer any questions you may have. Please send or fax this form to the Registration Department.

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Created 6-14
FORM # 41-30