Authorization for Proxy Access to Patient Portal
Parkview Medical Center

Patient Name:_____ DOB:_____

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

Proxy NAME:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone # (_____) _____-_____

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

I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view the same portions of my medical record that I am able to view. I also understand that additional information may be made available to my proxy through the portal as Parkview Medical Center continues to implement this product.

By signing this authorization, I am requesting Parkview Medical Center to give access to my proxy to utilize the patient portal. I understand that Parkview Medical Center will require my proxy to sign the acknowledgment at the bottom of this form and to agree to Parkview Medical Center's policies and procedures for use of the patient portal.

I understand that in the case of a minor (under the age of 14), proxy access will only be granted when authorized by someone with parental rights or legal guardianship over the patient. I also understand that the proxy agreement and proxy access ends once the minor has reached the age of fourteen (14).

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke/cancel this authorization. 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 federal privacy laws.

_____ I am between the age of fourteen (14) and eighteen (18) and agree to have above named individual be my proxy.

Patient Acknowledgment

Signature:_____ Date:_____Time:_____
Patient or Responsible Party

Proxy Acknowledgment

Signature:_____ Date:_____Time:_____
Patient's Proxy