PATIENT DEMOGRAPHIC STICKER HERE

Authorization for Proxy Access to Patient Portal
Bothwell Regional Health Center

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 Bothwell Regional Health Center's Patient Portal as my proxy.

(Please print)
Name:

_____

Date of Birth:

_____

Address:

_____

By signing this authorization, I am requesting Bothwell Regional Health Center to give access to my proxy to utilize 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 portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Bothwell Regional Health Center continues to implement this product.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or 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.

This authorization does not allow the release of any other content in my medical record other than what is accessible on the patient portal. If any other documentation is required the patient and/or legal guardian must obtain proper authorization. Contact the Health Information Department at Bothwell Regional Health Center for more information if needed.

Patient Acknowledgment

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian (if required) Date

_____ _____
Proxy Date