



**Adult Patient Portal Proxy Authorization Form**

(For an able adult granting another adult proxy to your Patient Portal account)

**Giving Others Access to your Medical Records**

- A proxy is a person who can access your information as if they were you
- A parent, spouse, adult child, or a caregiver may be granted full access to your medical records with proxy access.
- In order for an adult proxy (18 or over) to view information in the Patient Portal please complete the form below.
- Authorization for proxy access to an adult patient’s account is valid until revoked by the patient.

**1. Patient Information:** (Patient to which proxy access is required)

Patient Name \_\_\_\_\_ Medical Record # \_\_\_\_\_  
Address \_\_\_\_\_  
Previous Names \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_  
Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Email \_\_\_\_\_

**2. Proxy Information:** (Person wishing to access patient information to proxy)\*

Proxy Name \_\_\_\_\_ Medical Record # \_\_\_\_\_  
Address \_\_\_\_\_  
Previous Names \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_  
Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Email \_\_\_\_\_

Has Proxy been a Firelands Regional Health System Patient? Yes No

*\*Proper ID must be validated and scanned with this application*

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**I authorize Firelands Regional Health System to release medical information via the Patient Portal to:** The Designated Proxy named above.

**The following information is to be released:** Any and all information as allowed though the Patient Portal.

- I understand that I have a right to revoke this authorization at any time by notifying your provider’s office and requesting a password change.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact Firelands Regional Health System’s HIPAA Help Line at (419) 557-6912.
- I understand this authorization must be filled out completely and signed and dated in order to be considered valid, and activation of the Patient Portal proxy access feature must occur within 30 days from the date of this authorization.

Signature of Patient

Date