

The My Baptist Chart Patient Portal is a website that provides patients with web-based access to portions of their Baptist Health electronic health record. Please complete this authorization if you would like to **revoke or cancel** your Proxy's/Delegate's or your Teen's access to the electronic health information ("ePHI") maintained at Baptist Health through My Baptist Chart.

PATIENT INFORMATION			
PATIENT NAME: LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH: MM/DD/YYYY	GENDER:	LAST 4 NUMBERS OF SSN:
STREET ADDRESS:	CITY:	STATE/PROVINCE:	ZIP CODE:
EMAIL ADDRESS:		TELEPHONE NUMBER:	

PROXY/DELEGATE/TEEN INFORMATION			
I revoke/cancel the following individual's authorization to access confidential ePHI through the Patient Portal:			
PROXY/DELEGATE/TEEN NAME: LAST, FIRST, MIDDLE INITIAL		GENDER:	DATE OF BIRTH: MM/DD/YYYY
STREET ADDRESS:	CITY:	STATE/PROVINCE:	ZIP CODE:
EMAIL ADDRESS:			

SIGNATURE			
<p>By signing this document, I am requesting that Baptist Health revoke/terminate the Proxy's/Delegate's/Teen's access to confidential medical records of the Patient via the Patient Portal. I understand and agree (i) that this form will only terminate rights of the Proxy/Delegate/Teen to access information through the Patient Portal, (ii) this form will not terminate a Proxy's/Delegate's/Teen's rights to access information through other means if permitted by applicable law, (iii) this form will not terminate any other authorization for disclosures of information through means other than through the Patient Portal, and (iv) Baptist Health may decline to honor this form if the individual executing this form is not legally authorized to do so and/or is not legally authorized to restrict access to the Proxy/Delegate/Teen to information about the Patient. I further understand that any such revocation will not apply to any information already sent to the Patient Portal. If I have any questions about this form, I may contact Baptist Health Information Management Department at (904) 202-1347.</p>			
_____	_____	_____	_____
Signature of Authorized Individual	Relationship to Patient	Date	Time

<p>Submit Form:</p> <ol style="list-style-type: none"> DELIVER PAPERWORK IN PERSON TO: Baptist Medical Center Jacksonville, HIM Department, 800 Prudential Dr., Jacksonville, FL 32207 OR to your Physician Practice. MAIL FORM TO: Baptist Medical Center Jacksonville, HIM Department, Attention Patient Portal, 800 Prudential Dr., Jacksonville, FL 32207 OR to your Physician Practice.



**PATIENT PORTAL ACCESS
REVOCATION FORM**



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PATIENT LABEL