**Patient Portal Authorized Representative Access Request and Authorization Form**

**1. Patient Information:**

Patient Name: _____ Date of Birth: _____
Last First M.I.

Address: _____
Street Address City, State Zip Code

**2. Authorized Representative Information: (Person to whom you authorize Prairie Ridge to release the Patient Portal record)**

Authorized Rep Name: _____ Date of Birth: _____
Last First M.I.

Address: _____ Phone Number: _____
Street Address City, State Zip Code

Email address: _____

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3. Please check one of the boxes below that best describes the access requested.
(Please note that for all types of access, the patient's chart will be accessed through the Authorized Representatives Patient Portal account.)

**Adult Patient**

**Access to another adult's Patient Portal record**

(Note: This section also applies to Emancipated Minors. Emancipated Minors must provide proof of Emancipation.)

**Select One:**

☐Adult-capable Adult Patient:

• The patient should sign this form to provide authorization for release of their medical information.

• Authorization for proxy access is valid until revoked by patient.

☐Legal Guardian of Adult Patient: (Adults who have a surrogate relationship with another adult through a legal arrangement.)

**Select the option below that best describes the guardianship:**

☐Legal Guardian (court order)

☐Power of Attorney for Health Care

☐Other: _____

• If you are the legal guardian or you have durable power of attorney for healthcare for this patient, then this request must be accompanied by a copy of the legal paper work verifying your authority to have access to the patient's medical information.

• You must notify Prairie Ridge immediately in case of any change of authority.

**Authorization:**

• By signing this request, I understand that I am giving my permission for Prairie Ridge Healthcare to disclose my protected health information (PHI) through the Patient Portal to my Authorized Representative. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, etc.

• The information available to my representative may include information relating to: (1) Acquired Immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.

• This representative's request is effective until my Patient Portal account is inactivated or access is revoked or expires on this specific date: _____.

• This request includes health information that was created or existing on or before the date this form was signed, as well as health information that is created after the date this form is signed.

• I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my representative.

• I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Patient Portal account will not be granted.

**Patient/Legal Guardian:** By signing below, I acknowledge and agree that:

• I will comply with the terms and conditions on this document.

X_____ _____ _____

Patient or Legal Guardian Signature Relationship to Patient Date

**Authorized Representative:** By signing below, I acknowledge and agree that:

• I will be using my own Patient Portal account to access the patient's Patient Portal account.
• I will comply with the terms and conditions on this document.
• The patient can revoke my access to his/her Patient Portal account at any time

X_____ _____ _____

Authorized Representative Signature Relationship to Patient Date