# Authorization for Proxy Access to Patient Portal - Hospital
## Lake Regional Health System

Patient Name: _____ Patient Date of Birth:_____

Patient Address: _____

I authorize the following individual to participate in Lake Regional Health System Patient Portal as my proxy.

(Please print)
Proxy Name: _____

Proxy Address: _____

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 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 Lake Regional Health System continues to implement this service.

By signing this authorization, I am requesting Lake Regional Health System to give access to my proxy to utilize the patient portal. I understand that Lake Regional Health System will require my proxy to sign an acknowledgment and agree to Lake Regional Health System's policies and procedures for use of the Patient Portal.

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.

**Patient Acknowledgment**

_____
Signature of Patient or Legal Representative Date Time

**Proxy Acknowledgment**

_____
Signature of Proxy (Relationship) Date Time