Authorization for Proxy Access to MyCare Portal
Mary Rutan Hospital

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 Mary Rutan Hospital's MyCare Portal as my proxy.

(Please print)
Name:

_____

Date of Birth:

_____

Address:

_____

I understand that my proxy will have the same access and privileges that I have for the MyCare 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 MyCare Portal as Mary Rutan Hospital continues to implement this product.

By signing this authorization, I am requesting Mary Rutan Hospital to give access to my proxy to utilize the MyCare Portal. I understand that Mary Rutan Hospital will require my proxy to sign an acknowledgment and agree to Mary Rutan Hospital's policies and procedures for use of the MyCare 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 Date

Proxy Acknowledgment

_____ _____
Signature of Proxy Date