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# Portal Enrollment Form

110 West 6th Street, Oswego, NY 13126 HIM Office
Phone: (315) 349-5551

## Patient Portal Proxy Authorization and Request for Change Form

**Patients Information**
**All fields are required**

Patient's Name: ______________________ Date of Birth. ______________________

Address: ______________________ City, State, Zip: ______________________

Telephone No: ______________________

Would you like access to your Oswego Health Patient Portal Account? (If so a personal e-mail address must be provided)

E-mail address: ______________________

***Please print clearly***

Medical Record Number : ______________________(this is not intended to be shared with others)

______________________ ______________________
**Date** **Patient Signature**

______________________ ______________________
**Date** **HIM Representative**

Identification: Driver's License/ SS Card] Birth Certificate/ ID Badge/ Other: ______________________

**Request to Access Minor Patient Portal**
**(Age 0-11 years)**

Minor Patients Name: ______________________ Date of Birth. ______________________

Address: ______________________ City, State, Zip: ______________________

Telephone No: ______________________ Relationship to Minor Patient: ______________________

Would you like access to your Oswego Health Patient Portal Account? (If so a personal e-mail address must be provided)

E-mail address: ______________________

***Please print clearly***

Medical Record Number : ______________________(this is not intended to be shared with others)

**Proxy's Information (Requested by patient)**
**(If Proxy is present and has identification, complete entire section below)**

Proxy's Name: ______________________ Date of Birth: ______________________

Address: ______________________ City, State, Zip: ______________________

Telephone No: ______________________ Proxy's Relationship to Patient:

- ☐ **Spouse** ☐ **Sibling**
- ☐ **Parent/Legal Guardian**
- ☐ **Other:**

Proxy's e-mail address: ______________________ If Other, Please explain: ______________________

***Please print clearly***

I Authorize: Oswego Health to release information to the proxy listed below through the Oswego Health Patient Portal. This access will not expire without my in person written authorization. A photocopy of this authorization is as valid as the original.
I understand the guidelines regarding Oswego Health Patient Portal account information and agree to allow the proxy listed above access to my Oswego Health Patient Portal.

______________________ ______________________
**Date** **Patient Signature**

I understand the requirements for accessing the above named patient's Oswego Health Patient Portal. I certify that all that all the information I have provided is correct. I hereby request access to the above named patient's Oswego Health Patient Portal account.

______________________ ______________________
**Date** **Proxy Signature**

Identification: Driver's License/ SS Card/ Birth Certificate/ID Badge/ Other: ______________________

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## Request for Patient Portal Changes

***Must be done by the patient in person**

### Change Patient Portal E-mail Address:

Old:________________________________ New:________________________________

Patient Signature:________________________________ Date of Request:____________________

### Cancel Proxy Access:

Name of proxy to be canceled:________________________________________________

Reason for proxy to be canceled:________________________________________________

Patient Signature:________________________________ Date of Request:____________________

### Request to Deactivate Patient Portal:

Reason for Deactivation:________________________________________________

Patient Signature:________________________________ Date of Request:____________________

### Other Requests or Communications:

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Patient Signature:________________________________ Date of Request: ____________________

Identification: Driver's License/ SS Card/ Birth Certificate/ID Badge/ Other:________________________

## *For HIM Office Use Only:*

- ✓ **Document on Patient Portal Spreadsheet (S:Drive)**
- ✓ **Registration Notified**
- ✓ **IT Notified**
- ✓ **Other Dept. Notified (If Necessary)**________________________________

**Additional Comments:**________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

**Staff Signature:**________________________________ **Date changes were made in portal:** ____________________