Baptist HEALTH

BAPTIST HEALTH PATIENT PORTAL
PROXY ACCESS FORM

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Patient Name: _____ **Date of Birth:**_____

I authorize the following individual to participate in the Baptist Health Patient Portal as my proxy. (Proxy access is not intended for attorneys, insurance companies or group homes. Please refer those requests to Health Information Management).

****Please note that a copy of the patient's and patient's proxy's state or federal issued photo identification is required for processing this request.**

Name of Patient's Proxy (*Please Print*): _____

Mailing Address: _____**Zip Code:**_____

Email Address of Patient's Proxy: _____

I understand that my proxy will have the same access and privileges that I have to the Baptist Health Patient Portal ("the portal"). I understand and acknowledge that my proxy will have online access to my Protected Health Information (PHI). My PHI may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information. I also understand that additional information may be made available to my proxy through the portal as Baptist Health continues to implement this product.

By signing this authorization, I am requesting Baptist Health to give access to my proxy to utilize the portal. I further understand that Baptist Health requires my proxy to sign an acknowledgment and agree to the policy and procedures for use of the portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. 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 protected by federal privacy laws. I also understand that it is my responsibility to notify my proxy if I revoke his or her access to my PHI.

Patient Acknowledgment: If signed by the Legal Guardian, the Power of Attorney for Healthcare or Court Appointed Guardianship documents must accompany the request.

_____	_____	_____
Date	**Time**	**Signature of Patient/Legal Guardian**

Proxy Acknowledgment:

_____	_____	_____
Date	**Time**	**Signature of Proxy**