**Authorization for Proxy Access to Patient Portal**

 **Conway Regional Medical Center**

Patient’s Name: DOB:

Email Address

*(Please supply the email address of the person who will be using the patient portal)*

As my proxy, I authorize the following individual to participate in Conway Regional Medical Center’s Patient Portal.

*(Please Print)*

Proxy’s Name: DOB:

Address:

Relationship to patient:

I understand that my proxy will have the same access and privileges I have for the Patient Portal. This allows my online proxy access to my personal health information. My representative will be able to view portions of my record that I can view. I also understand that additional information may be made available to my broker through the patient portal as Conway Regional Medical Center continues to implement this product.

By signing this authorization, I am requesting Conway Regional Medical Center to give access to my proxy to utilize the patient portal. I understand that Conway Regional Medical Center will require my portal to sign an acknowledgment and agree to Conway Regional Medical Center’s policies and procedures for using the patient portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to withdraw or cancel this authorization. In the case of minor children, the proxy automatically expires when the child reaches the age of 18 years, and a new proxy request will be required. However, I understand that my revocation will not be effective as to uses and disclosures already made in reliance upon this authorization. I realize that the information used and disclosed under this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

**Patient Acknowledgment**

Signature of Patient Date:

**Proxy Acknowledgment**

Signature of Proxy Date: