REDWOOD AREA HOSPITAL

STRONG Healthcare. STRONG Community.

Authorization for Proxy Access to Patient Portal

Patient Name:_____ Date of Birth:_____

Address: _____ Phone:_____

I authorize the following individual to participate in Redwood Area Hospital's Patient Portal as my proxy. *(Please print)*

Name:_____ Date of Birth:_____

Relationship to Patient:_____ Phone:_____

Address: _____

Email Address:_____

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 Redwood Area Hospital continues to implement this product.

By signing this authorization, I am requesting Redwood Area Hospital to give access to my proxy to utilize the patient portal. I understand that Redwood Area Hospital will require my proxy to sign an acknowledgment and agree to Redwood Area Hospital'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 Date

Proxy Acknowledgment

_____ _____

Signature of Proxy Date

Return completed forms to Health Information Management department. *Form must be notarized if returned by mail.*

RAH0460 PROXYACCESS

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