Slocum-Dickson Medical Group, P.L.L.C. Patient Authorization for Proxy Access to Patient Portal

PATIENT INFORMATION:	
NAME:	DATE OF BIRTH:
ADDRESS:	MEDICAL RECORD NUMBER:
CITY:	STATE:
ZIP:	PHONE NUMBER:
EMAIL:	

If you are requesting Authorized Representative/Proxy patient portal access please check one of the boxes below.

□ Adult-to-Child (Access to your minor child's record)	• If your child is 0-12 years old: you will have full access to your child's patient portal account. • If your child is 13-17: you will be granted partial access to your child's patient portal account (appointment scheduling and immunizations) without your child's written consent. • If your child is 13-17: due to Federal and State confidentiality laws your child must give their written consent for you to obtain full access to their portal account.
□ Adult-to-Adult (Access to another adult's record)	The patient or patient's legal representative must sign this form to provide consent for access to the patient's portal account.
□ Legal Representative (Documentation required)	□ Legal Guardian □ Power of Attorney □ Other:_____

PATIENT – I understand that:

- I am not required to grant another person (proxy) access to my Patient Portal Account.
- I will not share my user login name and password with others and that Slocum-Dickson Medical Group, PLLC is not liable for inappropriate access to my Patient Portal information due to my failure to secure my login and password information.
- Slocum-Dickson Medical Group, PLLC will not be liable if I allow another person to access my Patient Portal account without following the appropriate proxy access procedure.
- It is my responsibility to select a confidential login name and password, to maintain this data in a secure manner, and to change this password and contact Slocum-Dickson Medical Group, PLLC immediately if I believe it may have been compromised in any way. Slocum-Dickson Medical Group, PLLC has the right to revoke access to the Patient Portal by a patient or their authorized representative, at any time, for any reason.
- It is my responsibility to ensure my e-mail address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me.
- By signing this document, I am acknowledging that I have read and understand the information above and I am granting this proxy to have access to my personal health information in my Patient Portal Account.
- My entire medical record is not available via the Patient Portal. In order to obtain a complete copy of the patient's medical record, I must contact the Release of Information Department.
- I may terminate this Authorized Representative/Proxy access to my Patient Portal Account at any time. I will be required to submit this revocation of access in writing to the Health Information Services Department.

AUTHORIZED REPRESENTATIVE/PROXY – I understand that:

- This authorized representative/proxy access is intended as a secure online access to this patient's personal health information via the patient's portal account.
- I may not share my login and password information with another person.
- It is my responsibility to select a confidential login name and password, to maintain this data in a secure manner, and to change this password and contact Slocum-Dickson Medical Group, PLLC immediately if I believe it may have been compromised in any way. Slocum-Dickson Medical Group, PLLC has the right to revoke access to the Patient Portal by a patient or their authorized representative, at any time, for any reason.
- It is my responsibility to ensure my e-mail address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me regarding this patient.

AUTHORIZED REPRESENTATIVE/PROXY INFORMATION:	
NAME:	DATE OF BIRTH:
PHONE NUMBER:	ADDRESS:
CITY:	STATE:
ZIP:	EMAIL:

By signing below, I acknowledge that I have read and understand this Patient Portal Authorized Representative/Proxy sign-up form and I agree to its terms. I choose to designate the person named above as my Authorized Representative/Proxy thereby allowing them access to my medical record via my Slocum-Dickson Medical Group, PLLC Patient Portal Account.

Patient Name (please print):_____

Patient Signature:_____ Date:_____

Authorized Representative/Proxy Signature:_____ Date: _____

Relationship to Patient:_____