Speare Memorial Hospital - *A Critical Access Hospital*
16 Hospital Road
Plymouth, NH 03264

Attach Patient Identification Sticker

PATIENT PORTAL PROXY

Name: _____ Date of Birth: _____

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

I authorize the following individual to participate in Speare Memorial Hospital's Patient Portal as my proxy:

(Please print)
Name: _____

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 SMH continues to implement this product.

By signing this authorization, I am requesting SMH to give access to my proxy to utilize the patient portal. I understand that SMH will require my proxy to sign an acknowledgement and agree to SMH'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.

Please note records for minors 12 and over will not be accessible by electronic methods

Patient acknowledgement

_____ _____
Signature of patient Date

Proxy Acknowledgement

_____ _____
Signature of Proxy Date