*my*Patient Portal

ASQUAM COMMUNITY HEALTH COLLABORATIVE

LRGHealthcare | SPEARE Memorial Hospital

Proxy Access Form

The myPatient Portal is a product of Asquam, LLC; a community health collaborative comprised of Lakes Region General Hospital; Speare Memorial Hospital; Franklin Regional Hospital and associated medical practices.

Patient Name: _____ Date of Birth: _____

I authorize the following individual to participate in myPatient Portal as my proxy: *(Please note health information for minors 12-17 is not accessible by electronic methods)*

Name (Please Print): _____

Mailing Address: _____

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

I understand that my proxy will have the same access and privileges that I have to myPatient Portal. I understand and acknowledge that my proxy will have online access to my protected health information. My protected health information 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 myPatient Portal, as Asquam continues to implement this product.

By signing this authorization, I am requesting *(Hospital Name)* _____ to give access to my proxy to utilize myPatient Portal. I further understand that *(Hospital Name)* _____ requires my proxy to sign an acknowledgement and agree to the policies and procedures for use of the Asquam 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. I also understand that it is my responsibility to notify my proxy if I revoke his or her access to my protected health information.

Patient Acknowledgement:

_____   _____   _____
Date   Time   Signature of Patient/Legal Guardian

Proxy Acknowledgement:

_____   _____   _____
Date   Time   Signature of Proxy

To be filed in the patient's health record
Original: 4/2017
Path: G:Medical Records/Forms