Uvalde Memorial Hospital ADM
Authorization for Proxy Access to Patient Portal

Uvalde Memorial Hospital

Name:

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 Uvalde Memorial's Hospital's Patient Portal as my proxy.

Please Print:

(Name)

(Date of Birth)

(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 available to my proxy through the patient portal as Uvalde Memorial Hospital continues to implement this product.

By signing this authorization, I am requesting Uvalde Memorial Hospital to view access to my proxy to utilize the patient portal. I understand that Uvalde Memorial will require my proxy to sign an acknowledgment and agree to Uvalde Memorial 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 lo long protected by federal privacy laws.

Patient Acknowledgement

(Signature of Patient) Date

Proxy Acknowledgement

(Signature of Proxy) Date