AUTHORIZATION FOR PROXY REVOCATION

LAKE REGIONAL HEALTH SYSTEM
Health Information Management
54 Hospital Drive, Osage Beach, MO 65065
FAX: 573-348-8396
Email: patientportal@lakeregional.com

This form must be completed by the patient and will be used to revoke proxy access to your Lake Regional Health System patient portal.

PATIENT NAME: _____

PATIENT ADDRESS: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

EMAIL ADDRESS: _____

Please list all persons that you are revoking access to view your patient portal via proxy access. Please allow one business day after submission of this revocation request to Health Information Management before the access is deactivated. The designated proxy individuals listed below will no longer have access to your patient portal records. By signing this form you understand that any records previously accessed by your designated proxy may be released by them and may no longer be protected by Lake Regional Health System.

PROXY NAME: _____

PROXY ADDRESS: _____

PROXY EMAIL ADDRESS: _____

Patient Acknowledgment

_____

Signature of Patient or Legal Representative Date Time