AUTHORIZATION FOR PROXY ACCESS TO PATIENT PORTAL

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 request access to your patient portal via proxy access.

Patient Information (individual requesting a proxy)
Do you currently have patient portal access? Yes / No

PATIENT NAME: _____PATIENT DATE OF BIRTH:_____

PATIENT ADDRESS: _____

PATIENT EMAIL ADDRESS: _____

I authorize the following individual/s to participate in Lake Regional Health System Patient Portal as my proxy.

PROXY NAME: _____

PROXY ADDRESS: _____

PROXY EMAIL ADDRESS: _____

I understand that this allows my proxy online access to my personal health information. My proxy will be able to view the same 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 Lake Regional Health System continues to implement this service. If this request is for proxy access to a minor child's patient portal, the proxy access will automatically terminate when the child turns 18 years old or becomes legally emancipated.

By signing this authorization, I am requesting Lake Regional Health System give access to my proxy to utilize the patient portal.

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 understand information accessed by my proxy may be re-disclosed by them without my knowledge and may no longer be protected by state or federal privacy regulations.

Patient Acknowledgment

_____
Signature of Patient or Legal Representative Date Time