CUMBERLAND HEALTHCARE

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

Authorization for Proxy Access to Patient Portal

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

I authorize the following individual to participating in Cumberland Healthcare Patient Portal as my proxy.

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____

Email Address: _____ Phone Number: _____

(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 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 Cumberland Healthcare continues to implement this product.

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

Patient/Patient Representative Acknowledgement

_____ _____

Signature of Patient / Patient Representative **Relationship to Patient**

_____

Signature of Witness