advocare

Patient Portal Proxy Authorization Form (18 years and older)

PATIENT Name:	
PATIENT Address:	
PATIENT Date of Birth:	
PROXY Name:	
PROXY Address:	
PROXY Telephone:	
PROXY Email:	

Proxy Relationship to the Patient:

□ Parent □ Spouse □ Adult Child □ Other (specify:_____)

□ Full Access □ Restricted Access

Authorization:

By signing this proxy request, I understand that I am giving my permission for Advocare, LLC to disclose my protected health information (PHI) through the Patient Portal to my designated proxy. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information. This proxy request is effective until my Patient Portal account is inactivated, proxy access is revoked, or will expire ten years from the date of authorization. This proxy request includes records that were created or existed on or before the date this form was signed, as well as records that are created after the date this form is signed. I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and submit to my Advocare provider's office. I understand that such a revocation will not have any effect on any information already released to my proxy. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy laws. I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, proxy access to my Patient Portal account will not be granted.

REPRESENTATIONS AND WARRANTIES BY EACH, THE PATIENT AND THE PROXY:

- I will not share my confidential log-in credentials with anyone else for use within the Patient Portal;
- I understand that the Patient Portal is not to be used in emergency situations. If there is a medical emergency or an urgent medical question, I will call 911 or contact an Advocare Provider directly;
- As the Proxy, I have read and understood the requirements for accessing the above-named Patient's Portal account information and agree to abide by the according terms and conditions. My signature represents that all of the information provided about me is correct;
- Advocare, LLC is not liable for any unauthorized access to your health information that may result from you and your Proxy not protecting your access credentials.

By signing below, I confirm all of the representations and warranties above, and as the Patient, hereby authorize my Proxy to have access to my medical information, and if the Proxy, hereby accepts the duties and responsibilities of being granted access to the Patient's medical information.

_____ _____

Patient Signature Date

_____ _____

Proxy Signature Date

For office use: ☐ **ID Verification Obtained** (*specify type)* _____