Pendleton Family Medicine
A Praxis Medical Group Company

PATIENT PORTAL AUTHORIZATION FOR GRANTING PROXY ACCESS

Patient Name:
Patient Date of Birth:

With our new Patient Portal system, you can elect to link friends or family to your patient portal. As a proxy, they will gain full access to your medical care and parts of your patient chart.

Patients who permit proxy access of their records do so at their own risk.
Proxies will be given their own User ID and Password to access the Patient Portal for the Patient who requested the proxy access. It is your responsibility to terminate proxy access if you no longer want your proxy to have access to your health care information through the Patient Portal.
Proxy access may be terminated at any time, without proxy consent.

I authorize Praxis Medical Group to grant the following individual access to my confidential health information through the Patient Portal:

Proxy Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: ________

Phone Number: ______________________________

Email Address Unique to Proxy: ______________________________

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization and I am authorizing Praxis Medical Group to grant the proxy I identified herein access to my confidential medical records via the Patient Portal.

- I understand that my proxy will have the same access and privileges that I have to my Patient Portal. Patients who permit proxy access of their records do so at their own risk. My proxy will be able to view the portions of my record that I am able to view.

- I understand that Praxis Medical Group is not responsible for the proxy's inappropriate use or publication of the information they gain access to through the Patient Portal.

- I understand that this authorization is valid until revoked by me and a written request is necessary to cancel or revoke 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 privacy laws.

Signature of Patient or Authorized Representative: ______________________________

Clinic Use Only: Date Proxy Access Provided: ___________ Access Provided By: ________________________

Printed Name of Patient or Authorized Representative: ____

Relationship to Patient: _____________________ Effective Date of Authorization: ____________________

Clinic Use Only: Date Proxy Access Provided: ___________ Access Provided By: ________________________