HORIZON HEALTH

Paris Community Hospital Proxy Authorization Form

PATIENT'S INFORMATION

All fields are required.

Patient's Name: _____ Medical Record Number #_____

Address: _____ Last 4 digits of SS# _____ DOB: _____

City, State, ZIP: _____ Telephone No: _____

AUTHORIZING ACCESS FOR (check box that indicates patient status)

☐ Child (Birth through 11 years of age) **Sign Box A**
☐ Adolescent (12 through 17 years of age) **Sign Box B**
☐ Adult (18 and older) **Sign Box B**

PROXY INFORMATION (person who will be receiving access to patient's health information) All fields are required.

Proxy's Name: _____ DOB: _____

Address: _____

City, State, ZIP: _____

Telephone No.: _____ Email: _____

Authorization Signatures

BOX A: I have read and understand the requirements for accessing the above-named patient's Paris Community Hospital Online account and agree to abide by these requirements. *This access will expire on the patient's 12th birthday.* A photocopy of this Authorization is as valid as the original. I certify that all the information I have provided is correct. I hereby request access to the above-named patient's portal account.

_____ _____
Date Signature of Parent or Legal Guardian

BOX B: I understand the Patient Portal will display medical information to the proxy requestor listed above. I understand the guidelines regarding Patient Portal account information including secure patient messaging and agree to allow the requestor listed below access to Patient Portal account information. I also agree to abide by the terms and conditions for use of Paris Community Hospital's Patient Portal. For any patient over the age of 12 years proxy access will be ongoing until which time access is revoked in person by the patient.

_____ _____
Date Signature of Patient or Legal Representative

Internal Use Only:
Patient or Parent/Legal Guardian have presented in person with completed application.
Employee's initials: _____ Employee's location: _____ Date: _____