Monroe
COUNTY HOSPITAL & CLINICS

A healing touch you know and trust

Request for Electronic Access to Health Information

Please allow 3 business days for processing

Please present this form in person at the clinic or hospital registration.

Patient Information	Person who may also view (Proxy)
Name	Name
Address	Address
Phone	Phone
Date of Birth	Date of Birth- Not necessary for Proxy XX-XX-XXXX
Last 4 digits SSN	Last 4 digits SSN- Not necessary for Proxy XXXX
Email	Email

For <u>Patient</u> Initiated Request:

I request electronic access to my health information at Monroe County Hospital & Clinics. I authorize the person listed above to also view my electronic health information. This authorization is voluntary. I may revoke this proxy access in writing at any time.

_____ _____

Patient Signature Date

For <u>Proxy</u> Initiated Request:

Relationship to Patient: (circle one) Parent[1] Durable Power of Attorney[2] Legal Guardian[3]

My signature represents that I have the legal right to this patient's health information. I understand that all proxy users may view messages and responses sent through the patient portal system.

_____ _____

Proxy Signature Date

For Monroe County Hospital & Clinics Internal Use:

Received date	☐ Approved ☐ Denied ☐ Patient Declined	Processed date
Reviewed by	Reason	

[1] Parent Proxy: On the child's 13th birthday proxy access will end. Your child then may re-authorize your proxy access or you may provide legal documentation as proof of your right to access this information

[2&3] DPOA and Legal Guardian: You must provide a copy of legal documentation as proof of your right to access this information.