Name: ____

MRN#: ____________________ DOB: _________________

Date of Service: _____________Acct# ________________

If no label write patient information in this box.

Authorization for Patient Portal by PROXY

Minors age 12-17: Section 18 of the NYS Public Health Law requires minors age 12 through 17 to determine who can access their patient portal. The minor also has the right to deny access to the portal, if they so choose. However, this does not affect any legal right a parent or qualified person has to access to a minor's medical record by other means. Please use Form # 01185 to request a paper copy or a CD/DVD.

This applies to Oneida Health Hospital, Oneida Medical Practices and Oneida Medical Services

Proxy information – all sections are required.

Name (last, first, middle initial): ______________________________________ Date of Birth: _____________________

Relationship to patient: ____ Phone Number: ________________________

Email Address (Print clearly):____

Patient's information – all sections are required.

Name (last, first, middle initial): ____ Date of Birth: ___________________

Street Address: ____ City: _____________________ State: _______

OH PATIENT PORTAL TERMS AND AGREEMENT FOR PATIENT GIVING PROXY ACCESS

I authorize Oneida Health to release the health information contained in my electronic medical record to the proxy listed above. I understand that my proxy will have the same access and privileges that I have for the Patient Portal and will be required to agree to the Terms and Agreements as presented upon accessing 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 Oneida Health continues to implement this product.

This form does not authorize release of my medical record to my designated proxy by other methods or in other forms. I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal or state privacy protections.

This authorization is valid and will remain in effect until revoked by me. I understand that I may revoke this at any time by providing a written request to Oneida Health. I understand that if I revoke this authorization, my designated proxy's access to my Patient Portal record will stop. I also understand my revocation will not apply to any disclosures that were made prior to processing the revocation request.

Patient Authorization to Allow Proxy Access

____ ________ ________ _______ ____

Signature of Patient Date Time

Proxy Acknowledgment

I understand that I will be required to agree and abide by the Oneida Health Patient Portal terms and conditions that will be presented to me when I access the Patient Portal

____ _________________ ___________

Signature of Proxy Date Time

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REV: 05/21