



Oneida Health
 Oneida Health Extended Care Facility
 Oneida Health Practices & Affiliates
 321 Genesee St. • Oneida, NY 13421
 ATTN: HIM Department
 Ph.: (315) 361-2027 Fax: (315) 361-2227

Authorization for Patient Portal by PROXY

This form may be used if you do not have an email address or internet access and/or would like to authorize another party to your view your protected health information (medical records) via the Patient Portal.

Exception; minors age 12-17*

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. This must be done by the minor, using their own email address, by creating a unique logon and password to access their portal and using the invitation process within the portal to allow the parent or legal guardian to view their protected health information. The minor has control to remove access at any time as they so choose. However, this does not affect any legal right a parent or qualified person has to access a copy of a minor’s medical record. Please contact the HIM Department or use Form # 01185 found on our website.

Minors’ age birth – 11: a parent or legal guardian has the right to access their child’s patient portal and can complete this form or contact the HIM department to add the child to the parent or legal guardian’s own patient portal. At the time the minor reaches the age of 12, access will automatically be de-activated and must follow the process noted above.

Proxy information – all sections are required. Please PRINT

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

Relationship to patient: _____ Phone Number: _____

Email Address (Print clearly): _____

Patient’s information – all sections are required. Please PRINT

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 (N/A for a minor age birth – 11)

 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

