



Consent and Authorization: Permission for Proxy Portal Access

Person Getting Access (Proxy)

Name: _____ Date of Birth: _____
Last First Middle Initial

Cell Phone Number: _____ Email: _____

Person Giving Access (Who Are You?) (Check One)

- I am the patient (I want to let someone else see my health information).
I take care of the patient (I have legal papers to make health decisions for them).
I am the parent or guardian of a child under 13 (I have legal rights to see their health information).
I am a foster parent of a child under 13 (I have legal papers that allow me to see their health information).
(If you have legal papers, you must bring them to us.)

Rules for Giving Someone Access

By signing this form, I understand:

- Upper Great Lakes Family Health Center will share my health information with the person I choose.
I can stop (cancel) access at anytime by notifying the health center and signing below.

If there is any health information I do not want this person to see, I should not sign this form.

X
Patient or Legal Guardian Signature Printed Name Date
X
Proxy Signature Printed Name Date
Completed by: _____ Staff Location: _____
Staff Signature Date

To Cancel Access

By signing below, I am requesting that the access for the above proxy be revoked, and access be removed.
X
Patient or Legal Representative Signature Printed Name Date
Completed by: _____ Staff Location: _____
Staff Signature Date