Loretto Hospital

Authorization for Proxy Access to Use My Loretto Health Patient Portal

Name: _____

Email Address: _____

(Please supply the email address of the person who will be using the patient portal)

I authorize the following individual to participate in "My Loretto Health", Loretto Hospital's Patient Portal as my proxy.

(Please print)
Name: _____

Date of Birth: _____

Address: _____

I understand that my proxy will have the same access and privileges that I have for My Loretto Health. 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, which may include information related to mental health and developmental disabilities, HIV, genetics testing and counseling, and substance abuse. I also understand that additional information may be made available to my proxy through the patient portal as Loretto Hospital continues to implement this product. However, I also understand that this form does not authorize release of my medical record to my designated proxy by other methods or in other forms (e.g., paper).

By signing this authorization, I am requesting Loretto Hospital to give access to my proxy to utilize My Loretto Health. I understand that Loretto Hospital will require my proxy to sign an acknowledgment and agree to Loretto Hospital's policies and procedures for use of the patient portal.

This authorization is valid until revoked by me at any time. I understand that a written request is necessary to revoke or cancel this authorization. I understand that if I revoke this authorization, my designated proxy's access to My Loretto Health record will end. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Designating a proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. I also understand that Loretto Hospital does not condition any of my treatment, payment, or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, Loretto Hospital is not permitted to provide access to My Loretto Health record to my designated proxy.

Loretto Hospital

This authorization will expire automatically five years from the date of my signature. I also may

Patient Acknowledgment

Signature of Patient _____ Date _____

Proxy Acknowledgment

Signature of Proxy _____ Date _____