JACKSON COUNTY MEMORIAL HOSPITAL and MEDICAL CLINIC
PATIENT PORTAL PROXY REQUEST FORM

PATIENT INFORMATION:			
PATIENT NAME: LAST, FIRST, MI	SEX:	DATE OF BIRTH	LAST 4 NUMBERS OF SSN:

STREET ADDRESS:	CITY	STATE	ZIP

HOME PHONE	OTHER PHONE	EMAIL ADDRESS

DESIGNATED PROXY:			
PROXY NAME: LAST, FIRST, MI	SEX:	DATE OF BIRTH	LAST 4 NUMBERS OF SSN:

STREET ADDRESS:	CITY	STATE	ZIP

HOME PHONE	OTHER PHONE	EMAIL ADDRESS

This form is being completed for one of the following reasons (check one):

[ ] I am a patient at Jackson County Memorial Hospital and/or Clinics (the "Organizations") who is 18 years old or over and **can make (and understand) my health care decisions** and wants to grant another person ("Proxy") access to portions of the my electronic protected health information ("ePHI") maintained at the Organizations through the JCMH Portal *["Patient Portal"]*.

[ ] I am a parent or legal guardian ("Proxy") who wants access to portions of my child's electronic protected health information ("ePHI") maintained at Jackson County Memorial Hospital and/or Clinics (the "Organizations") through the JCMH Portal *["Patient Portal"]*. I understand that there is no access to a child's Patient Portal account for a child ages 13 - 17 years old.

[ ] I am an individual ("Proxy") who has the correct legal documents to act as a legal guardian, an attorney-in-fact for healthcare decisions or a healthcare proxy under applicable Oklahoma laws for a patient of Jackson County Memorial Hospital and/or Clinics (the "Organizations") **who is 18 or over and cannot make (and understand) his/her health care decisions** and wants access to portions of the patient's electronic protected health information ("ePHI") maintained at the Organizations through the JCMH Portal *["Patient Portal"]*. I understand that I must present the legal documents to the Organization for verification prior to the access being granted.

Proxy:

By signing below, I acknowledge and agree that:

- I have read and fully understand the Jackson County Memorial Hospital Patient Portal User Consent Agreement and the Patient Portal Terms of Use and will comply with these terms and conditions as outlined in each document and this document.
- I will be using my own Patient Portal account at the Organizations to access the patient's Patient Portal account.
- I understand that the patient can revoke my access to his/her Patient Portal account at any time.

Designated Proxy Signature _____ Date _____

Relationship to Patient _____

Witness _____ Date _____

Place Patient Label Here

Patient over 18 and legally able to consent to providing Proxy access:

By signing below, I acknowledge and agree that:

- I have read and fully understand the Jackson County Memorial Hospital Patient Portal User Consent Agreement and the Patient Portal Terms of Use and will comply with these terms and conditions as outlined in each document and this document.
- I choose to designate the person named above as a Proxy to my Patient Portal account, thereby allowing him/her access to the ePHI in my JCMH Patient Portal account.
- I understand that if I no longer want the Proxy to have access to my Patient Portal account, I may either revoke his/her access through my JCMH Patient Portal account or by providing written notice to the JCMH Health Information Management Department at 1200 E. Pecan, Altus, Oklahoma.
- I have completed the Patient Portal Authorization for Use or Disclosure of Electronic Protected Health Information.

Patient Signature _____ Date _____

Relationship to Patient _____

Witness _____ Date _____

Jackson County Memorial Hospital Use Only

[ ] I have given a copy of the signed Patient Portal Proxy Authorization form to the Patient.

[ ] I have given a copy of the Jackson County Memorial Hospital Patient Portal User Consent Agreement and Patient Portal Terms of Use document to the Proxy.

[ ] I have verified the photo id on both the patient and proxy.

[ ] I have verified that the individual requesting access has the appropriate legal documents on file in PCI or I have attached copies of legal documents for all proxy requests related to a patient who is 18 or over and cannot make (and understand) his/her health care decisions.

[ ] I have explained to the patient that if they wish to revoke access to the proxy that they must do so through the JCMH Patient Portal or by completing the JCMH Proxy Revocation form and sending it to the JCMH Health Information Management department..

JCMH Staff Signature _____ Date _____

JCMH Staff Printed Name _____

JCMH Staff Department _____ Contact # _____

Completed form needs to be sent to HIM for scanning!

Place Patient Label Here