## JACKSON COUNTY MEMORIAL HOSPITAL and MEDICAL CLINIC PATIENT PORTAL PROXY REVOCATION FORM

The JCMH Patient Portal is a website that provides patients with web-based access to portions of their Jackson County Memorial Hospital (JCMH) and/or Jackson County Memorial Hospital Medical Clinic (JCMH Women's Health Associates, JCMH Pediatric Clinic, JCMH Orthopedic Clinic, JCMH Medical Clinic and JCMH Family Medical Clinic of Mangum) electronic health record. Please complete this authorization only if you would like to **revoke or cancel** proxy's access to your confidential health information through the JCMH Patient Portal.

ı. Pa	tient Information			
Na	Jame: I		Date of Birth:	
Str	reet Address:	Phone: _		
Cit	zy:	State:	Zip:	
Las	st 4 numbers of SSN:	Medical Record Number:		
l re	Proxy Information revoke/cancel the following individual from access to my confidential health information through the ICMH Patient Portal:			
Na	ame:	Date of Birth:		
Str	reet Address:			
Cit	zy:	State:	Zip:	
Las	st 4 numbers of SSN:	Medical Record Number:		
Re By sigr	ning this authorization, I am requesting	g that Jackson County Memorial H	lospital and/or the	e Jackson Count
Re By sigr Memo	ning this authorization, I am requesting this authorization, I am requesting orial Medical Clinics revoke/cancel the ortal for the proxy individual listed	g that Jackson County Memorial H access to my confidential health i above.	lospital and/or the nformation throu	e Jackson Count
Re By sigr Memo	ning this authorization, I am requesting orial Medical Clinics revoke/cancel the	g that Jackson County Memorial H access to my confidential health i above.	lospital and/or the	e Jackson Count
Re By sigr Memo	ning this authorization, I am requesting this authorization, I am requesting orial Medical Clinics revoke/cancel the ortal for the proxy individual listed	g that Jackson County Memorial H access to my confidential health i above.	lospital and/or the nformation throu	e Jackson Count
Re By sigr Memo	Printed Name of Individual or Personal Signature of Individual or Personal Return form to JCMH Health	g that Jackson County Memorial H access to my confidential health i above.	Date Date Date	e Jackson Count gh the JCMH
Re By sigr Memo	Printed Name of Individual or Personal Signature of Individual or Personal Return form to JCMH Health at 1200 E Peca	g that Jackson County Memorial Haccess to my confidential health is above.  All Representative  Representative  Information Management (medical representation)	Date Date Date Date	e Jackson Count gh the JCMH

ПТПОРТПРОЕ