Southwest
Medical Center

PATIENT PORTAL PROXY AUTHORIZATION

PHOTO IDENTIFICATION IS REQUIRED

Patient Name: _____

By affixing my signature hereto, I do hereby notify the Southwest Medical Center, Liberal, Kansas that I have designated the following individual or individuals as my health portal proxy/proxies:

Proxy #1

Name: _____ Date of Birth: _____

Address: _____

Email Address: _____

Proxy #2

Name: _____ Date of Birth: _____

Address: _____

Email Address: _____

As my health portal proxy, any of the individuals identified above can access any of my protected health information (PHI), through the Southwest Medical Center's Patient Portal. Any of the designated health portal proxies will have the same access and privileges that I have for the Patient Portal. My proxies will be able to view those portions of my record that I am able to view. Additionally, as the Southwest Medical Center continues to implement this product, more information may be made available for viewing by my health care proxies.

By signing this Authorization, I do instruct the Southwest Medical Center to give my proxies access to the Patient Portal. I understand that the Southwest Medical Center may, at its sole option, require my proxies to sign an authorization and, in any event, my proxies are required to follow all of the policies and procedures implemented by the Southwest Medical Center in regard to the Patient Portal. Failure of my proxies to

Southwest
Medical Center

comply with any such policies and/or procedures will give the Southwest Medical Center the absolute right to terminate the offending proxy's use of the Patient Portal.

This notification shall be valid until I notify the Southwest Medical Center, **in writing**, that I am revoking the same. I hereby release the Southwest Medical Center from any liability that may arise from allowing access to my PHI to any of the individuals identified in this notification and for a reasonable time after I have notified the Southwest Medical Center, in writing, that the designation is revoked. Further, any revocation will not apply as to any PHI released prior to the Southwest Medical Center's receipt of my revocation.

I release the Southwest Medical Center from any liability that may arise from any unauthorized access of my PHI, when such unauthorized access appears to be related to the sharing, whether intentional or unintentional, of any password or other information that is used to access the Patient Portal. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer subject to state or federal privacy laws.

_____	_____
Printed Name - Patient	Date of Birth
_____	_____
Signature/Relationship	Date
_____	_____
Email address	Phone Number
_____	_____
Witness	Date