BEVERLY HOSPITAL

Where Experience & Compassion Matter

AUTHORIZATION FOR PROXY ACCESS TO MY HEALTH PORTAL INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the following individual to participate in Beverly Hospital's My Health Portal as my proxy:

Patient Name: _____Patient Birth Date: _____
Proxy / Organization authorized to use or disclose the information: **BEVERLY HOSPITAL**

Proxy authorized to receive the information:_____

Proxy *Birthdate:* _____*(Proxy must be age 18 or over)*

Relationship:_____ Proxy Social Security#_____

Proxy e-mail address: _____

Proxy home address:_____

_____

Proxy home/cell phone: _____

I understand that this Authorization applies to all health information contained in My Health Portal. This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. 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.

Patient Signature _____Date: _____Time: _____A.M. / P.M.

Proxy Signature _____Date: _____Time: _____A.M. / P.M.