St. Claire HealthCare

222 Medical Circle | Morehead, KY 40351

Patient Portal Proxy Form

PATIENT INFORMATION:

Patient Name: _____ Date of Birth:_____
Last First MI

Address: _____
Street Address City, State Zip Code

Email Address: _____ Medical Record MR#:_____

Representative Name: _____ **Date of Birth** _____
Last First MI

Street Address: _____

City, State & Zip: _____

E-mail Address:_____ **Phone Number:** _____

Relationship to the Patient: _____

Does the representative have an active St. Claire HealthCare Patient Portal account? ☐ Yes ☐ No

Has the representative ever been a patient at St. Claire HealthCare? ☐ Yes ☐ No

****Please check one of the boxes below that best describes the access requested.**

_____**Minor Patient:** Representative must have parental/legal guardianship rights. Access will be granted until the child turns 18 years old.

_____**Legal Guardian of Adult Patient:** (Adults who have a surrogate relationship with another adult through a legal arrangement, such as power of attorney.)

_____**Other Representative** authorized by the patient (spouse, caregiver, etc.)

By signing below, I acknowledge and agree that:

- My authorized representative will have access to my personal health information through the patient portal.
- The authorized representative will agree with the Patient Portal Terms and Conditions prior to access.
- It is my responsibility to revoke the representative access to my personal health information by notifying St Claire HealthCare at 606-783-6570 of such request.

X_____ _____
Adult Patient Signature Date

OR

X_____ _____
If patient is a minor, Representative Signature Date