



PATIENT AUTHORIZATION FOR PROXY ACCESS TO PATIENT PORTAL

(Patient MRN) _____ (Date request made) _____

I _____
Full name of patient Date of birth

AUTHORIZE:

Proxy name Date of birth Relationship to patient

To participate in Eaton Rapids Medical Center's MyERMC Patient Portal as my proxy

Select and complete one of the following to fulfill authorization:

My Authorized Proxy is enrolled in a MyERMC Patient Portal

I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information through their own MyERMC Patient Portal.

My Authorized Proxy is NOT enrolled in a MyERMC Patient Portal

I understand I am requesting Eaton Rapids Medical Center to give access to my authorized proxy to utilize MyERMC Patient Portal to access my medical records. I understand that the email address, street address and phone number in the boxed section below is for the purpose of allowing my proxy to enroll in MyERMC Patient Portal and must be filled out by my above-named proxy.

Acknowledgement of Proxy for enrollment in the MyERMC Patient Portal *Only required for second option*

- Proxy Email Address:
Address: Street City State Zip Code
Phone Number:
Proxy Signature: Date:

By signing above I give Eaton Rapids Medical Center the authority to begin the enrollment process to MyERMC on my behalf. I understand that an email will be generated to the above email address with a onetime user I.D. and password which will be used to finalize the enrollment process. **Must Provide State Identification Card for Proof of Identity**

By signing this authorization I understand:

- My proxy will be able to view portions of my medical record.
Additional information may be made available to my proxy through the patient portal as Eaton Rapids Medical Center continues to implement this product.
Eaton Rapids Medical Center will require my proxy to sign an acknowledgment and agree to Eaton Rapids Medical Center's policies and procedures for the use of the patient portal if not already signed through ownership of existing MyERMC Patient portal.
This authorization is made in accordance with federal and state law and is valid until revoked by me.
I may revoke this authorization at any time by sending a written revocation to Eaton Rapids Medical Center except to the extent for uses and /or disclosures already made in reliance upon this authorization.
That once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal or state law.
A facsimile or photocopy of this document will be accepted in lieu of the original.

Patient Signature or Legal Guardian/Representative Date Relationship to Patient

Identified patient by: Photo identification Matching signature Personally known
Option 2 only Identified proxy by: Photo identification Matching signature Personally known

Witness Signature Date Witness Printed Name

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