Adult Proxy Access to Erie Family Health Center Patient Portal

Requirements and Procedures

Proxy access for adult patients allows another person, of the patient's choosing, to link the patient's Erie patient portal account to their own patient portal account. Linking the patient's portal account to their own will allow the proxy to view and manage the personal health information of the patient

Requirements for Proxy online access to a patient's record:

- Individual requesting access must have a signed consent from the patient Adult Proxy
- Access Authorization Form must be completed and signed

I understand that

- I must log-in to Erie Patient Portal with my own User ID and Password
- I agree to abide by the terms and conditions of the Erie Patient Portal site.
- Erie Patient Portal is not to be used in emergency situations. If I have a medical emergency or have an urgent medical question, I will call **911** or contact my health care provider directly.

Adult proxy access to a patient's record will be revoked upon the patient's written request. Erie Family Health Center reserves the right to revoke online access to medical information at any time.

Communications and requests on behalf of the patient must be sent from the patient's record; responses will be posted in the patient's Erie Patient Portal account. Erie Patient Portal email alerts will be sent to the email address entered in the patient's record.

You will be granted access to the record only after the completed Parent/Guardian Access Authorization Form is received.

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Adult Proxy Access to the Erie Patient Portal Authorization Form

Please enter the Delegate's information below:

Delegate Name_____
Address_____
City_____ State_____ Zip Code_____
Phone Number_____ Relationship to Patient_____

I acknowledge that I have read and understand the requirements and procedures for accessing this patient's Patient Portal account and medical record online. I certify that I am a delegate of the patient listed below and that all of the information I have provided is correct. I hereby request access to this patient's online Patient Portal account and medical record. This authorization is valid until it is revoked or expires.

_____ _____
Date
Signature of Delegate

Please enter the Patient's information below:

Patient's Name:_____

Address:_____

City:_____ State_____ Zip Code_____

Phone Number:_____ Email Address_____

Date of Birth:_____ Gender: Male_____ Female_____

I understand that the following items may be disclosed along with other health information in my health record: HIV/AIDS related information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drug/alcohol related diagnosis/treatment, referral information, genetic testing information and/or records, information about sexual assault/abuse, information about child abuse/neglect and domestic abuse of an adult with a disability. I understand that I may contact Erie Family Health Center at any time to revoke this consent and restrict delegate access to my patient portal account and personal health information.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Witness