MOUNT GRAHAM REGIONAL MEDICAL CENTER

Adult Proxy Authorization Form

Adult Proxy Access to the MyHealth Portal Online account for an adult 18 years of age or older.

PATIENT'S INFORMATION
All fields are required

Patient's Name:_____ Last 4 digits of SS#: _____DOB: _____

Address:_____ Gender: Male _____ Female: _____

City, State, Zip: _____ Telephone No: _____

Would you also like a MyHealth Portal Online Account?

Yes_____ If yes, please provide your e-mail address: _____
Please print clearly

No_____ *Selecting no indicates that all email notifications of activity in your account will be sent to your proxy's email address.*

I AUTHORIZE: Mt Graham Regional Medical Center to release all MyHealth Portal Online information to the proxy listed below. This authorization will expire on _____/_____/_____(MM/DD/YYYY). If I do not indicate a date, this access will not expire without my online or written authorization. A photocopy of this authorization is as valid as the original.

I have read and understand the guidelines regarding MyHealth Portal Online account information including secure patient messaging and agree to allow the proxy requestor listed below access to my MyHealth Portal Online account information.

_____ _____
Date Patient Signature

PROXY 'S INFORMATION
All fields are required

Proxy's Name:_____ DOB: _____

Address:_____ Gender: Male _____ Female: _____

City, State, Zip: _____ Proxy's Relationship to Patient:

Telephone No: _____ _____Spouse _____Parent or Legal Guardian

Would you also like a MyHealth Portal Online Account? _____Other If other, Please explain:_____

Proxy's e-mail address: _____
Please print clearly

Are you a MGRMC patient?

Yes_____ If yes, please provide the Last 4 digits of SS#_____

No_____ If no, please provide **entire** 9 digit SS#: _____-_____-_____

Please note that the social security number is required for authentication purposes and will be stored securely in compliance with applicable law.

I have read and understand the requirements for accessing the above named patient's MyHealth Online account information and agree to abide by these requirements. I certify that all that all the information I have provided is correct. I hereby request access to the above named patient's MyHealth Online account.

_____ _____
Date Patient Signature