Decatur County Memorial Hospital
The Quality Care You Want. Close By.

Authorization for Proxy Access to MyHealth Patient Portal
Decatur County Memorial Hospital

Patient's Full Name: _____ Date of Birth: _____

I authorize the following individual to participate in Decatur County Memorial Hospital's MyHealth Patient Portal as my proxy.

Proxy's Full Name: _____ Date of Birth: _____

Address: _____

Email Address: _____
(Please supply the email address of the person who will be accessing the patient portal on your behalf)

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. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Decatur County Memorial Hospital continues to implement this product.

By signing this authorization, I am requesting Decatur County Memorial Hospital to give access to my proxy to utilize the patient portal. I understand that Decatur County Memorial Hospital will require my proxy to sign an acknowledgement and agree to Decatur County Memorial Hospital's policies and procedures for use of the patient 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.

** *You must be 18 years old or older to have your own portal account.*

Patient Acknowledgement

_____ _____
Signature of Patient Date

Proxy Acknowledgement

_____ _____
Signature of Proxy Date

Authorization for Access to Records for Minors

I am requesting access to the records of _____, _____.
Minor's Name Date of Birth

Parent's Full Name: _____ Date of Birth: _____

I attest that I am the legal guardian of the named minor and understand my access will be terminated on the date the minor turns eighteen years old.

Legal Guardian Acknowledgement

_____ _____
Signature of Parent Date