PhoebePatient

ADULT PROXY REQUEST FORM

This form is to be completed by a patient of Phoebe Putney Health Systems (PPHS) who is 18 or over and **can make (and understand) his/her health care decisions** and wants to grant another person ("Proxy") access to portions of the patient's electronic protected health information ("ePHI") maintained at PPHS through Phoebe Patient.

Patient makes sure all fields/signatures are completed and shows photo ID in Health Information Management when submitting forms.

Patient Information: **If the patient will be logging into his/her Phoebe Patient account, the patient also needs to create a Phoebe Patient account.**

Patient's Name:		DOB:	
Address:			
Phone Number:		Last 4 SSN:	

Proxy Information: **If the Proxy sees providers at PPHS, the Proxy also needs to create an account in Phoebe Patient.**

Email Address:					
Proxy's Name:		Proxy's DOB:		Phone #:	
Street Address:					
City:		State:		Zip:	

Proxy:
By signing below, I acknowledge and agree that:

- I will be using my own Phoebe Patient account at PPHS to access the patient's Phoebe Patient account.
- I will comply with the terms and conditions on the Phoebe Patient web page (located at http://www.PhoebePatient.com, select the Phoebe Patient Portal Agreement link on the page) and this document.
- The patient can revoke my access to his/her Phoebe Patient account at any time.

X_____/_____/_____/_____
Proxy Signature (Required) **Relationship to Patient** (Required) **Date** (Required) **Time** (Required)

Patient:
By signing below, I acknowledge and agree that:

- I will comply with the terms and conditions on the Phoebe Patient web page (located at http://www.PhoebePatient.com, select the Terms and Conditions link on the page) and this document.
- I choose to designate the person named above as a Proxy to my Phoebe Patient account, thereby allowing him/her access to the ePHI in my Phoebe Patient account.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and mail it to: Phoebe Health System, Health Information Management, P.O. Box 3770, Albany, GA 31706. I understand that the revocation will not apply to information that has already been released.
- I have completed the Phoebe Patient Authorization for Use or Disclosure of Electronic Protected Health Information.

X_____/_____/_____/_____
Patient Signature (Required) Relationship to Patient **Date** (Required) **Time** (Required)

This proxy will expire 3 years from the signed date and will need to renewed to continue reviewing patient information.