FIRELANDSHEALTH
Firelands Regional Medical Center

* P O R T A L *

FIRELANDSHEALTH
Firelands Physician Group

Firelands Health Legal Guardian Patient Portal Proxy Sign Up

(Request proxy to the Patient Portal account of someone for whom you have a legal right)

Proxy Access to Medical Records

- A proxy is a person who can access patient information as if they were the patient.
- A parent, spouse, adult child, or a caregiver may be granted full access to medical records with proxy access.
- Authorization for proxy access to an adult patient's account is valid until revoked by the patient.
- Authorization for proxy access to a child's account is valid until the child turns 13.

1. Patient Information: (Patient to which proxy access is required)

Patient Name _____ _____Medical Record #_____

Address _____

Previous Names _____ Last 4 digits of Social Security #_____ _____

Birth Date_____ Home Phone _____ Work Phone_____

Email _____

2. Proxy Information: (Person wishing to access patient information)*

Proxy Name _____ _____Medical Record #_____

Address _____

Previous Names _____ Last 4 digits of Social Security #_____

Birth Date_____ Home Phone _____ Work Phone_____

Email _____

Relationship to patient:

☐ Legal Guardian ** ☐ Durable Power of Attorney for Healthcare (DPOA)**

** Proper ID must be validated and scanned with this Application*

***This request must be accompanied by a copy of legal paperwork verifying the patient's personal representative*

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize Firelands Health to release medical information via the Patient Portal to: The Designated Proxy named above.

The following information is to be released: Any and all information as allowed through the Patient Portal.

- I understand that I have a right to revoke this authorization at any time by contacting Firelands Health Records and requesting a password change.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact Firelands Health HIPAA Help Line at (419) 557-6912.
- I understand this authorization must be filled out completely and signed and dated in order to be considered valid, and activation of the Patient Portal proxy access feature must occur within 30 days from the date of this authorization.

_____

Signature of Patient/Authorized Person | Person's Authority to Sign (parent, guardian, power of attorney, etc.) | Date

Reason patient is unable to sign: _____

Firelands Health Staff Use Only

Was ID Validated? ☐ Yes ☐ No Name of FHS Staff _____