Authorization for Proxy Access to Patient Portal
Gordon Memorial Hospital District
Gordon Memorial Hospital/Gordon Clinic/Rushville Clinic
300 East 8th Street
Gordon, NE 69343

Name:
_____ MR#_____

I authorize the following individual to participate in Gordon Memorial Hospital District's Patient Portal as my proxy.

Proxy Name:

_____

E-mail Address:
_____
(Please supply the e-mail address of the person who will be using the Patient Portal)

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 Gordon Memorial Hospital District continues to implement this product.

By signing this authorization, I am requesting Gordon Memorial Hospital District to give access to my proxy to utilize the Patient Portal. I understand that Gordon Memorial Hospital District will require my proxy to sign an acknowledgment and agree to Gordon Memorial Hospital District'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.

Patient Acknowledgment

_____ _____
Signature of Patient Date

Witnessed By Name

_____ _____
Signature of Witness Date