Regional Health

EPROXY

Proxy Revocation

This form must be completed to revoke proxy access to your patient portal.

Patient information:

Name:_____ Date: _____

Address: _____

Phone Number: _____ Date of Birth: _____

E-mail Address: _____

Please list all persons you are revoking access to view your patient portal via proxy access. Please allow one business day after submission of this revocation request to health information management before the access is deactivated. The designated proxy individuals listed below will no longer have access to your patient portal records. By signing this form, you understand that any records previously accessed by your designated proxy may be released by them and may no longer be protected by Regional Health.

Proxy Name	Date of Birth	Relation to Patient	Proxy's e-mail address	Patient Signature (Patient/Legal Guardian if Patient is a Minor or Legal Representative)	Date/Time

OFFICE USE ONLY:

ID Verified: ☐ Yes ☐ No

Date Received: _____ Date Completed: _____

Caregiver Name PRINT: _____