FAMILY PRACTICE CENTER, P.C.

PATIENT PORTAL AUTHORIZED REPRESENTATIVE (PROXY) SIGN-UP FORM

PATIENT INFORMATION:		
Name:		Date of Birth:
Street Address:		FPC Acct #:
City:		Phone number:
State:	Zip:	Email:

If you are requesting Authorized Representative / Proxy access, please check one of the boxes below. Please note that, for all types of proxy access, the patient's chart will be accessed through an Authorized Representative patient portal account.

☐ Adult-to-Child (Access to your minor child's record)	Please note the following age range limitations for portal access as an Authorized Representative. These age range limitations do not affect any legal right you have to access your child's record by other means. - If your child is age 0-13 years: You will be granted full access to your child's portal via an Authorized Representative account. -If your child is age 14-17 years: Due to federal and state confidentiality laws, you may not access certain types of medical information without your child's consent (such as drug & alcohol, mental health, reproductive health and certain diseases). This is the law, this is not FPC policy. With your child's written consent, you may obtain portal access via an Authorized Representative account.
☐ Adult-to-Adult (Access to another adult's record)	The patient or patient's legal representative must sign this form to provide authorization for release of medical information in the form of a portal Authorized Representative account.
☐ Legal Representative (Documentation required)	☐ Legal Guardian (court order) ☐ Power of Attorney for Healthcare (documentation required) ☐ Other _____

PATIENT – I understand that:

- Use of the Patient Portal Authorized Representative is voluntary and I am not required to grant another person (proxy) access to my Patient Portal Account in this manner.
- By signing this document, I am acknowledging that I have read and understand the information above and I am granting this proxy to have access to my personal health information in the form of an Authorized Representative Portal Account.
- I may terminate this Authorized Representative's access to my patient portal account at any time by contacting FPC unless there is a court order in place granting this AR full access to my medical records.

AUTHORIZED REPRESENTATIVE / PROXY – I understand that:

- This Authorized Representative access is intended as secure online access to this patient's personal health information. I may not share its login and password information with another person.
- I may use this Authorized Representative access to send messages about this patient; I may not use this patient's personal patient portal account (adult patients only).
- It is my responsibility to select a confidential login name and password, to maintain this data in a secure manner and to change this password or contact FPC immediately if I believe it may have been compromised in any way. Access to the FPC Patient Portal is provided as a convenience to patients and their Authorized Representatives. Family Practice Center, PC has the right to revoke access to the Patient Portal by a patient or their Authorized Representative at any time for any reason.
- It is my responsibility to ensure that my e-mail address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me regarding this patient.

AUTHORIZED REPRESENTATIVE / PROXY INFORMATION		
Name:		
Street Address:		Date of Birth:
City:		Phone number:
State:	Zip:	E-mail:

By signing below, I acknowledge that I have read and understand this Patient Portal Authorized Representative Sign-Up Form and I agree to its terms. I choose to designate the person named above as my Authorized Representative (Proxy) thereby allowing them access to my medical record via my Family Practice Center, PC Patient Portal Account.

Name of Patient:	(Please Print)	
Signature of Patient:		Date:
Relationship to Patient:	☐ Parent ☐ Legal guardian ☐Power of Attorney ☐ Other: _____	
Signature of Authorized Representative:		Date: