PORTAL PROX

Authorization for Proxy Access to Patient Portal
Island Health

Name: _____

I authorize the following individual to participate in Island Health's *my*IslandHealth (patient portal) as my proxy.

(Please print)
Name: _____

Date of Birth: _____

Address: _____

Email Address: _____

I understand that my proxy will have the same access and privileges that I have for *my*IslandHealth. 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 myIslandHealth as Island Hospital continues to implement this product.

By signing this authorization, I am requesting Island Health to give access to my proxy to utilize *my*IslandHealth. I understand that Island Hospital will require my proxy to sign an acknowledgment and agree to Island Health's policies and procedures for use of *my*IslandHealth.

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

Proxy Acknowledgment

_____ _____
Signature of Proxy Date