Authorization for Proxy Access for Logansport Memorial Hospital Portal

Printed Patient Name:________________________ Patient Date of Birth:__________

Patient Street Address: ____

City:____________________ State:__________ Zip:______________

Last four digits of Patient's Social Security Number:________________________

I authorize Logansport Memorial Hospital, (as referred to as "LMH") to share medical information about me, the patient for whom I am the legal representative, as described below.

1. The following person may receive information from my medical records by having access to my records through the LMH Hospital Portal.

Name:________________________ Date of Birth:______________

Street Address:____

City:____________________ State:__________ Zip:______________

Relationship to Patient:____________________ Phone #:______________

2. The purpose is to provide access to those portions of my LMH electronic medical record available through the LMH Hospital Portal.

3. This authorization is voluntary and the access to my medical records through the LMH Hospital Portal shall remain in effect until I revoke or cancel it. I am aware that I may revoke or cancel the access at any time, except to the extent that action has already been taken in reliance upon it. To revoke or cancel this proxy access, I will send a signed and dated letter to Logansport Memorial Hospital, attn: Medical Records, 1101 Michigan Avenue, Logansport, IN 46947.

4. If I do not sign this form or if I later revoke or cancel my authorization, it will not affect any treatment, payment, or enrollment and/or eligibility of benefits which I am eligible to receive from LMH.

5. I confirm that I have had the opportunity to read and consider the contents of this authorization, and I agree to be bound to them. I release LMH from any legal responsibility or liability for providing LMH Hospital Portal proxy access to the person listed above. I understand that this person might not keep my information confidential and that it might not be protected by federal and state privacy laws any longer.

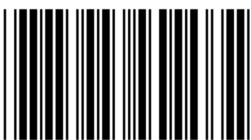
Signed Authorizations for Proxy Access should be presented to the Medical Records Department at the Logansport Memorial Hospital.

Patient/Parent/Legal Guardian/Legal Representative Signature:________________________

Relationship to Patient:________________________ Date:______________

MM930 4/14

1101 Michigan Ave. Logansport, IN 46947



AUTHORIZATION FOR PROXY ACCESS

FOR OFFICE USE ONLY

Patient Name:________________________

Medical Record #:________________________