Hixny Patient Portal Adult Proxy Form

Patient's Information: (All sections must be completed. Please print clearly.)

Name *(last, first, middle initial)*:____

Social Security Number (last four digits):__________ Date of Birth: __________

Street Address:________________________ City:____________________

State: ________ Zip: ________ Phone Number: (_____) _____ - ______

Email Address:________________________ @ ________________

To request access to the Hixny Patient Portal to obtain medical records of an adult whose medical care you help manage, please complete this form. The patients chart will be accessed through your access.

Hixny Patient Portal Terms and Agreement
I understand the portal is intended as a secure online source of confidential medical information.
If I share my ID and password with another person, that person may be able to view my record.

I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

I understand that Hixny Patient Portal contains selected, limited medical information from a patient's medical record and that the Hixny Patient Portal does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the Health Information Management Department of the Adirondack Medical Center.

I understand that use of the Hixny Patient Portal is voluntary and I am not required to use the Hixny Patient Portal or to authorize a proxy.

I understand that I may request to deactivate proxy access at any time.

Your Information: (All sections must be completed. Please print clearly.)

Proxy Name *(last, first, middle initial)*:____________________________________

Social Security Number (last four digits):__________ Proxy Date of Birth:__________

Street Address:________________________ City:____________________

State: ________ Zip: ________ Phone Number: (_____) _____ - ______

Email Address:________________________ @ ________________

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By signing below, I acknowledge I have read and understand the Hixny Patient Portal Adult Proxy terms on this form and I agree to abide by them.

______________________________	__________
Proxy's Signature	Date

____
Relationship to Patient

I acknowledge I have read and understand this Hixny Patient Portal Adult Proxy Form. I agree to its terms and choose to designate the person named above as my Proxy, thereby allowing them access to my medical record on the Hixny Patient Portal.

______________________________	__________
Patient's Signature	Date