Authorization for Proxy Access/Additional User to Patient Portal
Lincoln Surgical Hospital

(Please print)
Patient Name _____

Patient Date of Birth ____/____/_____ Patient Sex M / F **Patient MRN** _____

- **Proxy** is defined as a person without power of attorney acting on behalf of the patient.
- **Additional User** is defined as a person with power of attorney or guardian of a minor patient.

I authorize the following individual to participate in Lincoln Surgical Hospital's Patient Portal as my proxy/additional user.

Proxy/Additional User Name

_____

Proxy/Additional User Email Address

_____

I understand that my proxy/additional user will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy/additional user online access to my personal health information. My proxy/additional user will be able to view and edit the same portions of my record that I am able to view and edit. I also understand that additional information may be made available to my proxy/additional user through the Patient Portal as Lincoln Surgical Hospital continues to develop this product.

By signing this authorization, I am requesting Lincoln Surgical Hospital to give access to my proxy/additional user to utilize the Patient Portal on my behalf. I understand that my proxy/additional user will be required to agree to Lincoln Surgical Hospital's Terms of Use & User Agreement for use of the Patient Portal.

The proxy authorization is valid until revoked by me. I understand that a written request is necessary to cancel the proxy authorization. I understand that my cancelation will not be effective as to uses and/or disclosures already made. I realize that the information used and/or disclosed by this authorization may be subject to re-disclosure by proxy/additional user and no longer protected by federal privacy laws.

Patient Acknowledgment (Required for Proxy Authorization)

_____ _____
Signature of Patient Date

Proxy/Additional User Acknowledgment (if present)

_____ _____
Signature of Proxy/additional user Date

Lincoln Surgical Hospital Witness

_____ _____
Signature of Witness Date