NorthShore Health Centers
P.O. Box 1430
Portage, IN 46368
Phone: (219) 763-8112

Patient Portal Proxy Access Request and Authorization

Patient Information

Patient Name: ______________________________________ Date of Birth: _____________________

Address: ____ City/State/Zip: ____________________

Email: ____ Phone Number: ___________________

I authorize NorthShore Health Centers to allow the person named below to become my patient portal proxy. Information in my patient portal will be available to my proxy upon completion of this Authorization, which may include information related to mental health treatment, sexually transmitted diseases, HIV/AIDS, genetic testing, and records related to alcohol and substance abuse. **I understand that if there is information that I do not want my proxy to see, then I should not sign this authorization.**

I understand that once information has been disclosed to my proxy, it may potentially be re-disclosed by my proxy and the disclosed information may be protected by state or federal privacy laws. I agree that NorthShore health Centers and its agents are not responsible for my proxy's use or disclosure of the information accessed through my patient portal. I understand that authorizing my proxy to have access to my patient portal is voluntary. I understand that I do not need to sign this Authorization to receive treatment.

I understand that I may revoke this Authorization at any time and my proxy's access to my patient portal will be terminated. I understand that I must do so in writing and give my revocation to the Medical Records Department. For minors, the Authorization is valid until my 18th birthday unless I submit a written request to revoke proxy access to NorthShore Health Center's Medical Records Department. I understand that a revocation is not effective for uses and disclosures of my medical information that have already been made or other actions that have been take in reliance on this Authorization or as required by law. I understand that I am entitled to a copy of this Authorization.

Proxy Information

Proxy Name: _____________________________________ Date of Birth: _____________________

Address: ____ City/State/Zip: ____________________

Email: ____ Phone Number: ___________________

Patient Signature (not required for patients under 12)

I understand and agree to the terms and conditions of this Authorization. By signing below, I designate the person named above as my proxy and allow my proxy access to my NorthShore Health Centers patient portal.

____ __________________________

Signature of Patient/Authorized Representative Date