# Patient Authorization for Third-Party Access to Patient Portal

| Patient Name: | Date of Birth | Last 4 Social Security#: |
|---|---|---|
| Street Address: | City, State, Zip: | |
| Email: | Phone: | |

I authorize **Axis Health System to grant access** to the individual listed below to my patient portal to view my protected health information:

**Third Party Information:**

| Name of Individual: | Date of Birth | Relationship to Patient: |
|---|---|---|
| Street Address: | City, State, Zip: | |
| Email: | Phone: | |

**Authorization**

**For a third party to have access to a minor patient's portal (age 12-17), both the parent/legal guardian and minor patient must consent.**

I certify that this request is made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand granting **third party access to** the patient portal will allow the individual access to view all protected health information made available on the portal and may include but is not limited to **medical, family planning, behavioral health, psychiatric, substance use, sexually transmitted diseases/infections, HIV status**, and that by granting access, the protected health information may be re-disclosed by the third-party and may no longer be protected.

I may refuse to sign this authorization and refusal will not affect the ability to obtain treatment, affect payment or eligibility to obtain benefits. I understand the information on the portal contains limited data and does not include all health records associated with care at Axis Health System locations. I understand that if I authorize a third-party access to the patient portal, they may request, via the patient portal, all my health information as defined by Axis Health System's designated record set. If I need to obtain or authorize access to all my health records and/or need hard copies, I must complete the *Patient Request to Access Health Records Form* and submit it to Axis Health Information Management Department via the patient portal, email, fax, or mail. There may be a fee associated with obtaining such copies.

I understand that Axis Health System or I may revoke this third-party access to the patient portal for any reason at any time. I understand that Axis Health System has the right to terminate third party access to the patient portal immediately if there is a breach of the terms of use. I understand that I may request revocation of this authorization at any time by submitting a request for revocation within the patient portal account or by submitting a revocation in writing to Axis Health System.

Expiration: This authorization for third party access will not expire until I request revocation of this authorization by submitting a request within the patient portal account or by submitting a revocation in writing to Axis Health System.

Expiration-Minor Patients: If parent/legal guardian signed authorization for minor patient age 0-11, this authorization will expire automatically when the patient becomes 12 years old. Separate third party consents are required by minor patients (age 12-17) and parent/legal guardian of said minor patient.

**Signature and Date**

Signature: _____ Date: _____

Authorized Party's Signature (Check: ☐ Parent/Guardian OR ☐ Minor Patient)

*I attest that I am the patient listed above. If I am not the patient, I attest I have legal authority to sign on behalf of the patient; my ability has not been limited/restricted voluntarily or through legal process. Verification of legal documents may be requested.

If Representative/Parent/Legal Guardian, Print Name: _____ Relationship to Patient: _____

**AHS Use Only –** Patient# _____

☐Request Approved ☐Request Denied, reason: _____

281 Sawyer Drive, Suite 100, Durango, CO 81303 / Phone# 970-828-2526 /Fax# 970-247-7885
HIM@axishealthsystem.org