



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

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.

Signature and Date

I am allowed (have legal authority) to sign on my own or on behalf of the patient; my ability has not been limited/restricted voluntarily or through legal process. I understand Axis Health System may ask for legal documents for verification.

Signature: _____ Date: _____
 Patient/Legal Representative's Signature

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