Cherokee Nation Patient Portal Proxy Form

Please complete the following patient information:

_____

Name of Patient (Print)

_____

Date of Birth (Print)

_____

Street Address (Print) **City State ZIP**

_____ _____

Name of Proxy (Print) **Relationship to Patient** (Print)

_____@_____

Complete Email of Proxy (Print)

For the patient:
By signing below, I understand that my Cherokee Nation Patient Portal is my secure online source of confidential patient protected health information. I wish to grant proxy access to the above listed individual and I acknowledge that I am responsible for anything the proxy may do with my confidential information. I further understand that I cannot limit what information the proxy has access to and anything I have access to on my patient portal will also be available to the proxy named above. This includes information related to testing, diagnosis, treatment or prescribing of contraception, pregnancy, communicable disease (including secually transmitted diseases), and drug/substance and alcohol counseling/treatment. I understand that I can revoke this proxy at any time by contacting Medical Records. This proxy shall remain in effect until I revoke it.

_____ _____

Signature of Patient **Date**

For the proxy:
By signing below, I understand that I am being granted access to the above listed patient's Cherokee Nation Patient Portal as a proxy for the patient. I understand that the information contained on this portal is confidential patient health information and is to be protected at all times. I further understand that to sign up for the portal, I will have to provide a username and password and that I cannot share this username and password with anyone else.

_____ _____

Signature of the Proxy **Date**

_____

FOR OFFICE USE ONLY

Identity of Patient Verified By: _____

Patient's MRN: _____