Garden City Hospital

Patient Portal and Proxy Access and Authorization

This form is for **adult** patients (18 and over) to grant proxy access to other adults or legal representatives only

Completion of this form is voluntary and allows another person to view your health information in GCHealth, the Patient Portal for Garden City Hospital. To gain this access, this form must be completed, along with appropriate documentation provided below, and signed.

Patient's Information (All fields required – please print clearly)

Name: ___________________________________ Date of Birth: ____________ Phone Number: _________

Last, First, Middle Initial

Street Address: ____________________________ City: ___________________ State: _____ Zip Code: _______

Email Address: ____

Adult Proxy's Information (All fields required – please print clearly)

Name: ___________________________________ Date of Birth: ____________ Phone Number: _________

Last, First, Middle Initial

Street Address: ____________________________ City: ___________________ State: _____ Zip Code: _______

Email Address: ____

I, _________________________, permit Garden City Hospital to release protected health/medical information *only* through the Patient Portal, GCHealth, to ________________________.

Initial Below:

____ I understand that giving proxy access to this person will allow them to view the same information that I can view in the Patient Portal. This includes records that were created or existing prior to signing this form.

____ I understand that once information has been disclosed, there is potential for it to be re-disclosed by my proxy and will not be protected by state or federal privacy laws.

____ I understand that the protected information may include, but is not limited to, testing, diagnosis and treatment related to physical and mental illness, alcohol and/or drug abuse, STDs, HIV/AIDS.

____ I understand that I may revoke this proxy at any time by contacting the Health Information Management Department at Garden City Hospital in writing at 6245 Inkster Rd., Garden City , MI 48135.

Proxy Access Request:

____ **Capable Adult Patient**

The patient must sign this form to provide authorization for the proxy to receive access his/her health information GCHealth, the Patient Portal for Garden City Hospital. Any termination of this authorization must be submitted in writing, and does not apply to previously viewed/released records.

____ **Legal Representative of Adult Patient** (Please check which best describes your relationship.)

- ☐ Legal Guardian
- ☐ Power of Attorney for Health Care

You **must** provide Garden City Hospital with a copy of this legal paperwork as to confirm your authority to obtain proxy access to the patient's medical information in GCHealth.

By signing below, I acknowledge that I have read and understand the Patient Portal access and authorization form. I agree to the terms and designate the above named person as my Patient Portal Proxy, allowing them access to my medical information on GCHealth.

____

Patient Signature Date

By signing below, I acknowledge that I have read and understand the Patient Portal access and authorization form. I agree to and will comply with the terms herein, and know that my proxy can be revoked at any time, either by the patient, or by Garden City Hospital for any reason.

____

Proxy Signature Date

For GCH use only: ____ IDs checked ____ Guardianship Papers on File ____ Power of Attorney on File Staff Initials ________

Please send this original, completed form to HIM for processing and give the patient a copy for their reference.