



## Revoke Portal Proxy Form

\*Email signed form to [PatientPortalSupport@brooksrehab.org](mailto:PatientPortalSupport@brooksrehab.org)

### PATIENT/RESIDENT INFORMATION

Patient/Resident Name: \_\_\_\_\_ Medical Record Number # \_\_\_\_\_  
Address: \_\_\_\_\_ Last 4 digits of SS# \_\_\_\_\_ DOB: \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_ Telephone No: \_\_\_\_\_

### REVOKE INDIVIDUAL ACCESS

I request the following individual be revoked as my Patient/Resident Representative in Brooks Rehabilitation patient portal.

Patient/Resident Representative: \_\_\_\_\_  
Email address: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

### PATIENT/RESIDENT AUTHORIZATION

By signing this authorization, I am requesting Brooks Rehabilitation to revoke the above named Legal Representative or Resident Representative from accessing my patient portal. I understand that this means my Legal Representative or Resident Representative will no longer have access to my personal health information.

The previously signed authorization granting the Legal Representative or Resident Representative access is no longer valid and is revoked by me. I understand that written request is necessary to revoke or cancel this authorization. I understand that revocation will not be effective immediately but on the next business day. I realize that the information used and/or disclosed prior to this revocation may be subject to re-disclosure and no longer protected by federal privacy laws.

\_\_\_\_\_  
Signature of Patient/Resident or Legal Representative

\_\_\_\_\_  
Date

**PROXY INFORMATION (person who will be receiving access to my Health Information)** All fields are required.

Proxy's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Email: \_\_\_\_\_

Proxy's Relationship to the Patient: (Check Box)

Parent

Other

Legal Guardian

Power of Attorney for Health Care

If you are the Legal Guardian or Power of Attorney for Health Care you must provide a copy of the guardianship letters of office or executive Power of Attorney for Health Care verifying your authority to have access to the patient's medical information.

### PROXY SIGNATURE

By signing below, I acknowledge and agree that I will use my own patient portal account to access the patient's portal information and that I will comply with all usage requirements and terms and conditions of use for the patient portal, including but not limited to my agreement not to share login or password information, to establish a confidential login name and password, to maintain all data in a secure manner, and to ensure that my email address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me regarding this patient. I acknowledge that access to the patient portal is provided as a convenience to patients and their authorized representatives and may be revoked at any time for any reason.

\_\_\_\_\_  
Signature of Proxy

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Patient  
(Parent, Legal Guardian, Power of Attorney for Health Care, etc.)

Once completed please route to **HIM** for scanning

Revised 05/2023