BROOKS Rehabilitation

Patient/Resident Portal Revoke Proxy Authorization Form

Email completed form to 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The previously signed authorization granting the Legal Representative or Resident Representative access is no longer valid and is revoked by me.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.)