MORRIS HOSPITAL
& HEALTHCARE CENTERS
150 West High Street
Morris, IL 60450
www.morrishospital.org
People You Know. Extraordinary Care.

Adult Proxy Form
18 Years and Older

1 R O I

Patient Name: Date of Birth:

Address: _____

Phone: _____

I authorize the following individual to participate in Morris Hospital and Healthcare Centers patient portal, My Health@morrishospital.

(Please Print)

Proxy Name: Date of Birth:

E-mail Address:

Proxy's Relation to Patient:

□Power of attorney	□Spouse	□Life partner	□Guardian	□Daughter	□Son
□Ward of court	□Father	□Mother	□Foster parent	□Step parent	
□Relative other	□Brother	□Sister	□Aunt/Uncle	□Grandparent	□Friend

I agree to allow access to: ☐ Billing ☐ Clinical Data ☐ Family History ☐ Download Medical History ☐ Profile

(If you would like to give full access please check all boxes above)

I understand that my proxy will have the same access and privileges that I have for My Health @ Morris Hospital Patient Portal. I understand that this allows my proxy online access to my personal health information.

My proxy will be able to view the portions of my record including sensitive information such as substance abuse, mental health issues, HIV and pregnancy from current and previous related visits. My proxy will view all Electronic Personal Health Information (ePHI) that I am able to view. I understand that additional information may be made available to my proxy through the patient portal as Morris Hospital continues to increase electronic medical record documentation.

By signing this authorization, I am requesting Morris Hospital & Healthcare Centers to give access to my proxy to utilize the patient portal. I understand that Morris Hospital & Healthcare Centers will require my proxy to sign an acknowledgement and agree to Morris Hospital's policies and procedure for use of the patient portal.

This authorization is valid until I complete the Revocation Form and return it to Morris Hospital Medical Records.

However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Patient Acknowledgement

Signature of Patient Date

Signature of Proxy Date

Witness to Signature Date

Print Witness to Signature

Please return this form using one of the following methods:

Email: myhealthmedicalrecords@morrishospital.org

Mail: Morris Hospital & Healthcare Centers (Attn: Medical Records) 150 W. High St Morris, Il 60450

Fax: Morris Hospital Medical Record Department Secure Fax 815-942-3203

Office Use Only:

MR# or DD# _____ Release Completion Date: _____ By :_____(mnemonic)

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