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

Authorization for Proxy Access to Morris Hospital and Healthcare Centers Patient Portal

1 R O I

Please select the Patient Portal you are requesting proxy access to:
☐ **Morris Hospital Portal and or ☐ Healthcare Centers (Physician Office) Portal**

Patient Name: Date of Birth:

Address: _____

Phone: _____

I authorize the following individual to participate in Morris Hospital and Healthcare Centers patient portal, My Health and or Healow as my proxy.

(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 understand that my proxy will have the same access and privileges that I have for My Health @ Morris Hospital Patient Portal and or the Healow 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 implement this product.

. 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 revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. 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