☐ ID verified ☐ Minor

Staff initials: _____ Medical Record #: _____ (completed by LMH)

Licking Memorial Hospital Authorization for Patient Portal Access

Please complete the following section to the best of your ability.

Patient name: _____
Last First Middle Maiden name (if applicable)

Address: _____

City:_____ State: _____ Zip: _____

Date of birth:_____ E-mail address: _____

The Licking Memorial Hospital (LMH) My.LMHealth.org Patient Portal access is intended for: (Please check mark only one box)

☐ **Me Alone – I am the Patient**
Please remember to sign page 2

☐ **Only my Appointed Proxy**
(Please complete the "Granting Proxy Access" section below)

☐ **Both – Me & my Proxy**
(Please complete the "Granting Proxy Access" section below)

Granting Proxy Access

Complete this section **ONLY** if you would like to give someone else access to your medical record information

Proxy access gives someone that you trust the ability to view your medical record information on the internet using the LMH My.LMHealth.org Patient Portal. Proxy access will also allow the designated person(s) the ability to update/modify your patient profile information, including your email address and Portal password. You may cancel your access and / or your Proxy's access at any time by sending written notification with a signature to the LMH Medical Records Department, or by visiting in person and completing the 'Revocation of Authorization Access' section.

I hereby authorize Licking Memorial Hospital to give the following appointed Proxy access to my online health record using the LMH My.LMHealth.org Patient Portal.

Proxy's full name:_____
Last First Middle Maiden name (if applicable)

Address:_____

City:_____ State: _____ Zip: _____

Proxy's date of birth:_____ Proxy's E-mail: _____

REMEMBER: Please sign under the "Authorization of Information" section to confirm your Proxy's access

Relationship to Patient:

☐ Spouse / Significant Other
☐ Durable Power of Attorney for Healthcare**
☐ Caregiver for senior patient*
☐ Custodial parent
☐ Legal guardian**
☐ Non-custodial parent*

☐ Other (please specify):_____

**See following page for explanation*
***See following page for explanation*

Medical Record #: _____ (completed by LMH)

**This request MUST be accompanied by patient signature or legal paper work verifying authority of personal representative.*
***This request MUST be accompanied by a copy of legal paperwork verifying the authority of the patient's personal representative (i.e. court appointed guardian, durable power of attorney for health care).*

For minor children: Is there a court order or restraining order in effect limiting the requesting individual's access to the minor's medical records and information? ☐ **Yes** ☐ **No**

Authorization for Release of Information

SIGN HERE to authorize you or your Proxy's access to the Patient Portal

As the patient or patient's personal representative / parent, I hereby authorize Licking Memorial Hospital (LMH) to release health information on the above-named patient using the LMH Authorization for Patient Portal Access form. I understand and acknowledge that access may include the patient's treatment for physical and mental health illness, alcohol / drug abuse, and / or HIV / AIDS (confidential) test results or diagnoses, if applicable. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that at any time I may discontinue my Patient Portal access as a patient, as a proxy, and / or discontinue my proxy's access by providing written notification to the LMH Medical Records Department requesting that access be terminated. Address: LMH Medical Records Department at 1320 West Main Street, Newark, OH 43055 or fax: 220-564-4129.

By signing below, you agree that LMH reserves the right to change, suspend or terminate your authorized access at our own discretion. For this authorization to be valid, activation of the Patient Portal access must occur within (30) thirty days from the date of authorization. I understand that revocation will not apply to information that has already been released in response / reliance on this authorization. I understand that LMH does not condition any of my health treatment, payment or other services on whether I provide this authorization. I understand that this form does not authorize the release of patient records to the designated proxy by other methods or means. I understand that once information has been disclosed and / or downloaded, the information may potentially be re-disclosed and may not be covered by privacy protections. I understand if I download my health information to a computer or other electronic device, I am solely responsible to protect this information.

For Minors: Ohio State law mandates that the LMH Patient Portal Proxy access automatically expire for minor children at the age of 18, unless it is otherwise revoked in the event of a minor emancipation. Should Proxy expiration occur, adults 18 and older will be responsible for signing a new Authorization for Patient Portal Access form.

_____	_____	_____
Date	Signature of Patient/Parent/Guardian/Power of Attorney	Relationship to Patient

Revocation of Authorization

Complete this section **ONLY** if you would like to cancel your current portal access and / or Proxy's access to your medical record information

I elect to revoke my authorization of the LMH My.LMHealth.org Patient Portal access and / or the Proxy listed below, except to the extent that Licking Memorial Hospital has relied on my previous authorization. This revocation will not have any effect on any actions taken prior to receiving the revocation.

Remove access from (please check):

Patient: ☐ Proxy: ☐ Proxy's full name_____
Last First Middle Maiden name (if applicable)

Proxy's date of birth: _____

_____	_____	_____
Date	Signature of Patient / Parent / Guardian / POA	Relationship to Patient

Licking Memorial Hospital

Authorization for Patient Portal Access

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4/22/14, 2/13/15, 12/5/2016