CONCORD HOSPITAL
250 Pleasant Street, Concord, NH 03301
(603)225-2711 **www.concordhospital.org**

MY PATIENT CONNECT AUTHORIZATION FOR PROXY ACCESS

Patient name:_____ DOB:_____ Sex:_____

Address:_____

Phone number(s):_____

I authorize the following individual to participate in Concord Hospital's My Patient Connect as my proxy.

Name of proxy:_____ DOB:_____ Sex:_____

Relationship to patient:_____

Email address:_____

(Please supply the email address of the person who will be using My Patient Connect.)

I understand that my proxy will have the same access and privileges that I have for My Patient Connect. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy though My Patient Connect as Concord Hospital continues to implement this product.

I understand that patient information within My Patient Connect may contain information related to drug and/or alcohol treatment, sexually transmitted disease, HIV (AIDS) testing/treatment, treatment for psychiatric conditions, and genetic testing.

By signing this authorization, I am requesting Concord Hospital to give access to my proxy to use My Patient Connect. I understand that Concord Hospital will require my proxy to sign an acknowledgment and agree to Concord Hospital's terms and conditions for use of My Patient Connect. If my proxy and I use the same email address and password, we agree to share any password revisions with each other. I will not permit another person to access my user name and password and if I learn or suspect that my user name or password has been wrongfully used or disclosed, it is my responsibility to immediately reset my password and promptly notify Concord Hospital at patientportal@crhc.org.

This authorization is valid until revoked by patient or proxy. I understand that a written request is necessary to revoke or cancel this authorization. I also 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 Acknowledgment

_____ _____

Patient/Legal Guardian signature **Date and Time**

Proxy Acknowledgment

_____ _____

Proxy signature **Date and Time**

Send completed form to: Support Analyst, Health Information Management Services
Concord Hospital, 250 Pleasant Street, Concord, NH 03301
Fax: (603) 230-7351