KNOXVILLE Hospital & Clinics
YOUR CORNERSTONE TO HEALTH

Request for Electronic Access to Health Information

Please allow 3 business days for processing

Please present this form at the hospital or your clinic.

Patient Information	Person who may also view (Proxy)
Name	Name
Address	Address
Phone	Phone
Date of Birth	Date of Birth
Last 4 digits SSN	Last 4 digits SSN
Email	Email

For Patient Initiated Request:

I request electronic access to my health information at Knoxville Hospital & Clinics. I authorize the person listed above to also view my electronic health information. This authorization is voluntary. I may revoke this proxy access in writing at any time.

_____ _____

Patient Signature Date

For Proxy Initiated Request:

Relationship to Patient: (circle one) Parent[1] Durable Power of Attorney[2] Legal Guardian[3]

My signature represents that I have the legal right to this patient's health information. I understand that all proxy users may view messages and responses sent through the patient portal system.

_____ _____

Proxy Signature Date

For Knoxville Hospital & Clinics Internal Use:

Received Date	☐ Sent Invitation to Patient ☐ Decline Documented in PowerChart and Email Field ☐ Missing Information – Did not send invitation ☐ Has not been entered into computer (invitation or decline)
Completed by	Completed Date

[1] Parent Proxy: On the child's 13th birthday proxy access will end. Your child then may re-authorize your proxy access or you may provide legal documentation as proof of your right to access this information

[2&3] DPOA and Legal Guardian: You must provide a copy of legal documentation as proof of your right to access this information.