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 patient's portal (Proxy)**
Name	Name
Address	Address
Phone	Phone
Date of Birth	
Last 4 digits SSN	
Email to be used for portal access:	

Sign below to authorize or request proxy access

(No signature is needed if patient is requesting access to their own portal account.)

For Patient Initiated Request:

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 ☐ 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.