

Request for Electronic Access to Health Information

Please allow 3 business days for processing

Please present this form at the hospital or your clinic.

An Affiliate of **MERCYONE**SM

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) Parent¹ Durable Power of Attorney² Legal Guardian³

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	<input type="checkbox"/> Sent Invitation to Patient <input type="checkbox"/> Decline Documented in PowerChart <input type="checkbox"/> Missing Information – Did not send invitation <input type="checkbox"/> 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.