

Adult Proxy Form 18 Years and Older



Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I authorize the following individual to participate in Morris Hospital and Healthcare Centers patient portal, My Health@morrishospital.

(Please Print)

Proxy Name: _____ Date of Birth: _____

E-mail Address: _____

Proxy's Relation to Patient:

- | | | | | | |
|--|----------------------------------|---------------------------------------|--|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Power of attorney | <input type="checkbox"/> Spouse | <input type="checkbox"/> Life partner | <input type="checkbox"/> Guardian | <input type="checkbox"/> Daughter | <input type="checkbox"/> Son |
| <input type="checkbox"/> Ward of court | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Foster parent | <input type="checkbox"/> Step parent | |
| <input type="checkbox"/> Relative other | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Aunt/Uncle | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Friend |

I agree to allow access to: Billing Clinical Data Family History Download Medical History Profile

(If you would like to give full access please check all boxes above)

I understand that my proxy will have the same access and privileges that I have for My Health @ Morris Hospital Patient Portal. I understand that this allows my proxy online access to my personal health information.

My proxy will be able to view the portions of my record including sensitive information such as substance abuse, mental health issues, HIV and pregnancy from current and previous related visits. My proxy will view all Electronic Personal Health Information (ePHI) that I am able to view. I understand that additional information may be made available to my proxy through the patient portal as Morris Hospital continues to increase electronic medical record documentation.

By signing this authorization, I am requesting Morris Hospital & Healthcare Centers to give access to my proxy to utilize the patient portal. I understand that Morris Hospital & Healthcare Centers will require my proxy to sign an acknowledgement and agree to Morris Hospital's policies and procedure for use of the patient portal.

This authorization is valid until I complete the Revocation Form and return it to Morris Hospital Medical Records.

However, I 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 Acknowledgement

Signature of Patient _____ Date _____

Signature of Proxy _____ Date _____

Witness to Signature (must be 18 years old or older) _____ Date _____

Print Witness to Signature _____

Please return this form using one of the following methods:

Email: myhealthmedicalrecords@morrishospital.org

Mail: [Morris Hospital & Healthcare Centers \(Attn: Medical Records\) 150 W. High St Morris, IL 60450](#)

Fax: Morris Hospital Medical Record Department Secure Fax 815-942-3203

Office Use Only:		
MR# or DD# _____	Release Completion Date: _____	By : _____ (mnemonic)

MH# 1276 9/2024