Ascension Texas
Austin, TX 78723

Patient Portal Proxy Form (Adult)
(Form B)

Proxy Access to a Patient Portal

To sign up for access to a patient's portal that is not your own, please complete this Proxy Form. Completing this form will establish a Patient Portal record for you and the listed patient. You will need to submit a government issued ID for verification when completing this form.

Revocation of Access for a Proxy

To revoke Proxy access to a Patient Portal, please complete section D of this form. Completing this section will remove the proxied person's ability to view all medical information within the said patient's portal.

A. Patient Information (To Be completed by the patient requesting access. All Sections required. Please Print Clearly.)

Full Name _____ Date of Birth _____ Sex: M / F

Street Address:_____ City:_____ State:_____ Zip: _____

Last 4 of SSN: _____ Phone Number:_____ Phone Type:_____

B. Proxy Access Information (All Sections required. Please Print Clearly.)

Full Name _____ Date of Birth _____

Street Address:_____ City:_____ State:_____ Zip: _____

Email Address:_____

C. Patient Portal Terms and Agreement

- I understand that the Patient Portal is intended as a secure online source of confidential medical information. If I share my Patient Portal ID and Password with another person, that person may be able to view my health information, and health information about someone for whom I have Patient Portal proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner and to change my password if I believe it may have been compromised in any way.
- I understand that access to the Patient Portal is provided by Ascension as a convenience to its patients and that Ascension has the right to deactivate access to the Patient Portal at any time for any reason. I understand that use of the Patient Portal is voluntary, and I am not required to use the Patient Portal or to authorize a portal proxy.
- By signing below, I acknowledge that I have read and understand this Patient Portal Proxy form and the Ascension Terms and Conditions, and attest that I am the patient of the names medical record.

Patient Portal Proxy Form (Adult)

(Form B)

Signature of Patient: _____ Date: _____ Time: _____

Printed Name of Patient: _____

Relationship to Patient: _____

D. Revocation of Proxy Access

Printed Name of Proxy: _____

Relationship to Patient: _____

Signature of Patient: _____ Date: _____ Time: _____

Printed Name of Patient: _____