

## PATIENT PORTAL THIRD PARTY ACCESS AUTHORIZATION FORM

Patient Name:			Date of Birth:				
	Last	First		M.I.			
Address:		treet Address		City, State	Zip Code		
Telephone #:		Med	dical Record #:		Social Security #:		
Provider Nam					Last 4 digits		
Trovider Nam	c (II KIIOWII)	·-					
permission to a	ccess my M ent problem	ySite Patient Portal a list, current medicati	and all of the info	ormation poste	giving the individual listed below d there, including: my health formation and other protected		
<ul> <li>This indivires revoke this</li> <li>My Patient signed.</li> <li>In the even protected b</li> <li>I have the I understant Information</li> <li>I can also contact the second of the second of</li></ul>	dual may be Acquired in and other s treatment f mental or b results of g dual will hav individual's Portal may  t, this indivi y federal or right to revo d that if I wan Manageme change my pa o close my a	exually transmitted of drug or alcohol abordary or alcohol abordary or alcohol abordary or access to my MyS access in writing as contain records that dual shares or re-senstate privacy laws. It is authorization and to revoke this authorization or the Privacy Of assword or ask any of account at any time.	ondrome (AIDS), diseases (STDs); buse; psychiatric care; site Patient Portal described below were created or ends any information at any time, and thorization, I mustificer of the hospi	human immurand  I until my acco  existing on or b  on from my Pa  terminate this st do so in writ ital.	nation relating to: nodeficiency virus (HIV) infection, unt is cancelled or deactivated or I before the date this form was stient Portal it may no longer be individual's access to my account ing to the Director of Health spitals in Milton, Needham, and		
X							
Patient Si	gnature		Date				

Date

Relationship

Patient's Legal Representative Signature

## THIRD PARTY ACCESS AUTHORIZATION FORM (continued)

Name:		Relation	onship to Patient:	
Last	First	M.I.	•	
Address:				
Street Address		City, State	Zip Code	
Telephone #:	Email Add	ress:		
Do you currently have a MySite according Needham, or Plymouth? Yes				
If I am a parent or legal guardian,	, I acknowledge and agr	ee that:		
• I will be using my Patient Port	tal account to access		's Patient Portal account.	
• I have parental rights or legal g				
<ul> <li>I have not been denied periods</li> </ul>				
restraining orders in effect lim				
	1		ent from the patient's record and	
responses will be received in the		it Portal e-mail ale	rts will be sent to the e-mail	
<ul><li>address entered on the Patient</li><li>For a child age 0 to 13 years, I</li></ul>		es to the child's Day	tiont Portal record	
<ul><li>For a child age 0 to 13 years, 1</li><li>For adolescents aged 13 to 17</li></ul>				
through the Patient Portal if th		nowed shared acce	55 to then hearth information	
care proxy, health care surro provide a copy of the corresp	ogate, or you have a durab ponding paperwork to the ty is inactivated, revoked, g. Notification should be s	e hospital. In the every terminated, or exp	vent there is a change in your pired), you must immediately	
• I will comply with the terms and co			onditions.	
• The patient can revoke my access t	to his/her Patient Portal ac	ecount at any time		
X				
Signature (Required)	Relationship to Patient	t (Required)	Date (Required)	
Beth Israel Deaconess Hospitals use	e only:			
Individual Who Received Request:		Date	Request Received:	
Medical Record Number / Account N	umber.			
Individual Completing the Request: _	Date I	Date Request Completed:		
I .				