SLV Health Patient Portal Proxy Consent

Patient Name: _____ Today's Date: _____

Patient Date of Birth: _____

I hereby authorize San Luis Valley Health to allow the following individuals access to all information in my SLV Health Patient Portal Account, including but not limited to and for the purpose of; requesting treatment, appointment requests and inquires, insurance and/or demographic updates, payment and/or enrollment updates and viewing and/or printing patient records and results.

First and Last Name of Proxy	Email Address	Relationship to Patient

I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment) and that I may revoke this authorization in writing at any time. If I do so, it will not affect any actions already taken by San Luis Valley Health based upon this authorization.

By signing below, I understand if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule (HIPAA), the information used as described above may be re-disclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal laws may prohibit the recipient from re-disclosing specially protected information, such as substance abuse treatment, HIV/AIDS-related information, and psychiatric/mental health information.

EXPIRATION EVENT: This authorization will expire upon revocation by me.

_____ _____

Patient or Authorized Individual (Signature) Date

_____ _____

Printed Name if signed on Behalf of the patient Relationship (Parent, Power of Attorney, etc.)