Family Medicine Associates
Patient Portal Proxy
Authorization Form

Family Medicine Associates is making it easier for you or your health care proxy to communicate with Providers, review test results, and maintain personal health records through its *Your**Health**File® Patient Portal!* This **Patient Portal Proxy Authorization** is for:

- **A patient** who wants to permit another person, such as a spouse or an adult child, to access its *Your**Health**File® Patient Portal* account.

- **An authorized representative of an adult patient**, such as a legal guardian or other legally authorized representative who makes health care decisions on a patient's behalf, to request access to a patient's its *Your**Health**File® Patient Portal*.

Proxy access is only granted for one year and will automatically expire. This process will need to be repeated yearly for ongoing patient portal proxy access.

To request patient portal proxy access, please **submit this completed authorization form** (and any supporting documentation) to the Family Medicine Associates Privacy Officer in one of the following ways:

1 Fax the documents to (877) 347-6094
2 Scan and email the documents to portal.support@familymedicineassoc.com
3 Mail the documents to:
Family Medicine Associates
ATTN: Privacy Officer
75 Springfield Rd. Ste. 1
Westfield, MA 01085
4 Drop-off the documents at our Reception Desk, at the above address.

Please note: You will be notified by email when our staff approves your *YourHealth**File® Patient Portal* proxy request.**

If you have additional questions, please call our office and ask for the Privacy Officer: 413-562-5173 June 26, 2020

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PATIENT'S INFORMATION

Patient's Name (print): _____

Date of Birth: ____/____/_____ Gender:_____ Phone Number:_____

Address: _____ City, State, Zip: _____

I authorize Family Medicine Associates to release all information in the *Your**Health**File® Patient Portal* ***to the proxy listed below. I am signing this Authorization voluntarily, and these records are released at my request. I understand that I have the right to revoke this authorization by contacting the Family Medicine Associates Privacy Officer. I understand that once disclosed, the information in my portal may be redisclosed by my proxy and is no longer protected by state or federal privacy laws.***

Signature of Patient or Authorized Representative: _____
Date: ___/____/____

If signing as an Authorized Representative of the Patient, you certify that you are the (check one):

☐ Parent ☐ Legal Guardian* ☐ Healthcare Proxy (for a patient determined to be incapacitated)* ☐ Power of Attorney (for health care matters)* ☐ Executor of Estate of Deceased Patient* ****Proof of relationship may be required.***

PROXY'S INFORMATION
(A PROXY IS THE PERSON, OTHER THAN PATIENT, REQUESTING ACCESS TO THE PORTAL)

Proxy's Name (print): _____

Date of Birth: _____/_____/_____

Proxy's Email (required, print clearly,
CAPS)_____@_____

Address: _____

City: _____State: _____ Zip code:_____ Phone:_____

For Office Use Only - Please Do Not Write Below This Line

FMA Staff:

Type of Proxy (check one):

☐ Parent ☐ Legal Guardian ☐ Healthcare Proxy (for a patient determined to be incapacitated)
☐ Power of Attorney (for health care matters) ☐ Executor of Estate of Deceased Patient

Proxy Relationship Verified: Yes_____ No_____ Initials:_____
Record Reviewed: Yes_____ No_____ Initials: _____ Patient Portal Access completed: Yes_____ No_____ Initials: _____