Revoke Proxy Access to Patient Portal Authorization

Patient Name: _____

Date of Birth: _____

Address_____City_____State_____Zip____

Phone Number: _____

I request the following individual to be **revoked** as my Proxy in the Your**Health**File® Patient Portal**.**
Proxy Name: _____

Relationship to Patient: _____ Date of Birth: _____

By signing this authorization, I am requesting Family Medicine Associates revoke the above-named proxy's access to my patient portal. I understand that this revokes my Proxy online access to my personal health information. My Proxy will no longer be able to view information contained within my patient portal that I am able to view.

I understand that Family Medicine Associates will revoke Proxy of this user to Patient Portal and any access to my medical information in the Patient Portal.

The previously signed authorization granting Proxy Access is no longer valid and is revoked by me. I understand that this written request is necessary to revoke or cancel this authorization. However, I understand that revocation will not be effective immediately but on the next business day. I realize that the information used and/or disclosed **prior** to this revoked proxy authorization may be subject to re-disclosure and no longer protected by federal privacy laws. *I, in no way hold Family Medicine Associates responsible for any information obtained by this proxy prior to revoking authorization.*

Patient Acknowledgment

_____

Signature of Patient or Legal Representative (include relationship to patient)

Date: _____ Time: _____

DELIVER THIS COMPLETED AND SIGNED FORM IN PERSON TO: FAMILY MEDICINE ASSOCIATES | 75 SPRINGFIELD RD. STE. 1 | WESTFIELD, MA 01085

NOTE! Your signature must be notarized if not submitting form in person. Send notarized form to:

Family Medicine Associates
ATTN: Privacy Officer
75 Springfield Rd. Ste. 1
Westfield, MA 01085

STATE OF MASSACHUSETTS
(COUNTY OF _____)

On this _____ day of _____, 20___, before me, the undersigned Notary Public, personally appeared and, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed above, and acknowledged that he/she executed it.

Witness my hand and official seal. _____

Notary Public

Verbal permission has been obtained. Reason verbal permission is necessary:

Name of associate completing_____,date_____time_____ of the revocation.

A signed/notarized Revoked Proxy form must be forwarded to Family Medicine Associates as soon as possible even if verbal permission has been obtained.

6/26/2020