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 *YourHealthFile*® Patient Portal. This **Patient Portal Proxy Authorization Form** is for:

- **A patient** who wants to permit another person, such as a spouse or an adult child, to access their *YourHealthFile*® Patient Portal. patient portal account.
- An adult child accessing their elderly parent's patient portal account.
- A nurse or caretaker accessing their patient's patient portal account.
- A partner accessing their significant other's 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 *YourHealthFile*® Patient Portal.

An adult patient may grant proxy access to any other adult upon completing the **Patient Portal Proxy Access Authorization Form**. If the adult patient is incompetent, their legal representative must sign the Patient Portal Proxy Access Authorization Form in addition to the proxy in order for others to be granted proxy access.

*Only **one proxy and one email address** can be provided on each proxy form, along with that (single) proxy's signature. If multiple people are to be granted proxy access, a separate proxy access form must be completed and signed for each proxy.Each proxy must use a unique email address.*

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. Upload completed form, along with any supporting documention, from Family Medicine Associate's Secure/HIPAA - Compliant web form, and select as recipient: ***Privacy Officer:*** Secure File Upload <<**Ctrl+Click** *Windows* or **Cmd+Click** *Mac.*

3 Mail the completed 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 the Privacy Officer approves your *YourHealthFile*® Patient Portal patient portal proxy request.

If you have additional questions, please call our office and ask for the Privacy Officer: 413-562-5173 Patient Portal Proxy Request Form

February 7, 2024

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PATIENT'S INFORMATION

All Fields Are Required

Patient's Name (print):

_____

Date of Birth: _____/_____/_____Gender:_____

Phone Number:_____

Email Address (if applicable): _____

Address: _____ City: _____

State: _____ ZIP: _____

I authorize Family Medicine Associates to release all information in the YourHealthFile® Patient Portal to the proxy listed below. I am signing this Authorization voluntarily, under no coercion, and these protected health records are released at my request. I understand that I have the right to revoke this authorization at any time by contacting the Family Medicine Associates' Privacy Officer. I understand that if I authorize the disclosure of my health information to someone who is not legally required to keep it private and confidential, it may no longer be protected by state or federal privacy and confidentiality laws.

Signature of Patient or Authorized Representative:

_____ Date: ___/_____/_____

If signing as an *Authorized Representative* of the Patient, you certify that you are the (You must 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)

Name (print in CAPS):

Last Name: _____

First Name: _____

Date of Birth: _____/_____/_____

Email Address: (REQUIRED, print clearly in CAPS.) **Note! This must be a unique email address, not shared. This can not be the email address of the patient.** Sharing login information between patients and care partners can breach HIPAA compliance standards for patient portal access. Additionally, it can result in patients being locked out of their account.)

Email: _____

Address:_____

City: _____State: _____ Zip code:_____

Phone:_____ (Mobile/Landline)

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 Granted: Yes__ No__ Initials: _____

If not granted, reason: