

NEW ENROLLEE

| PROXY | ACCESS |
|--------------|---------------|

PATIENT PORTAL & PROXY ACCESS

P.O. Box 9161 Monroe, LA 71211

| PATI | FNT | INFO | RMA | TION |
|------|------|------|--------|-------|
| 1711 | LIAI | HALO | IZIAIN | 11014 |

| Patient Name: | | | | _ Date of Birt | h:/_ | | |
|--|--|---|---|--|--|--|--|
| LAST | FIRST | M.I. | | | | | |
| Address: | | | | | | | |
| Street Address | | City | S | tate | Zip Code | | |
| Email Address: | (Personal email address only, please | | | | | | |
| I have read and understand benefits of patient portal an hospital and the patient. I of that using the patient portal Hospital should I decide aga | d agree that I understa consent to the condition is entirely voluntary a | and the risks ass ns outlined in the nd will not impac | ociated with onling Patient Portal Ir | ne communicat nformation docu | ions betwee ument. I ac | en the knowledge | |
| Patient Signature | | | | Date | | * | |
| PROXY INFORMATION (Per | rson to whom you autho | orize Monroe Surg | ical Hospital to rel | ease Patient Por | tal access) | | |
| Proxy Name: | | | | Date of Birth: | : / | 1 | |
| LAST | FIRST | M.I. | | | , | | |
| Address: | | | | Phone: | | | |
| Street Address | City | State | Zip Code | 1 110110. | | | |
| Email Address: | | | | (Personal ema | ail address o | only, please) | |
| Please Indicate the Proxy A | | | | - · | | ,,,,,, | |
| access valid until re Legal Guardian of Adarrangement. A col Surgical in case of a Minor Patient – Must be accompanied by health, STDs, menta | t sign this form to provoved by the patient. dult Patient - Legal gu py of the legal docume my change in authority st have parental rights y a copy of the court or al health, and/or substor patient. | eardian by court ent must accom y. s or legal guardia rder appointing cance abuse will | order, Power of a pany this request inship rights. If a the guardian. Inf only be made av | Attorney for He form. You mu guardianship e formation regal | ealth Care, court notify Me exists, this reduced reproduced the court of the court | or other legal onroe request must ductive | |
| By signing below, I acknowl | edge and agree that: | | | | | | |
| | wn Patient Portal acco | | | | | | |
| 5 6 | he conditions outlined | | | | | | |
| The patient can rev | oke my access to his/l | her Patient Port | al account at any | time | | | |
| Proxy Signature | | | | Date | | | |
| Patient Signature (if applicabl | le) | | | Date | | | |