MonroeSurgical Hospital

P.O. Box 9161
Monroe, LA 71211

PATIENT PORTAL & PROXY ACCESS

_____ NEW ENROLLEE _____ PROXY ACCESS

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/_____/_____
LAST FIRST M.I.

Address: _____
Street Address City State Zip Code

Email Address: _____ (Personal email address only, please)

I have read and understand the Monroe Surgical Hospital Patient Portal Information document. I understand the risks and benefits of patient portal and agree that I understand the risks associated with online communications between the hospital and the patient. I consent to the conditions outlined in the Patient Portal Information document. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Monroe Surgical Hospital should I decide against using the patient portal.

_____ _____
Patient Signature **Date**

PROXY INFORMATION (Person to whom you authorize Monroe Surgical Hospital to release Patient Portal access)

Proxy Name: _____ Date of Birth: ____/_____/_____
LAST FIRST M.I.

Address: _____ Phone: _____
Street Address City State Zip Code

Email Address: _____ (Personal email address only, please)

Please Indicate the Proxy Access outlined below that describes the proxy access requested:

_____ Adult – Patient must sign this form to provide authorization for release of his/her medical information. Proxy access valid until revoked by the patient.

_____ Legal Guardian of Adult Patient - Legal guardian by court order, Power of Attorney for Health Care, or other legal arrangement. A copy of the legal document must accompany this request form. You must notify Monroe Surgical in case of any change in authority.

_____ Minor Patient – Must have parental rights or legal guardianship rights. If a guardianship exists, this request must be accompanied by a copy of the court order appointing the guardian. Information regarding reproductive health, STDs, mental health, and/or substance abuse will only be made available to a parent or guardian with consent of the minor patient.

By signing below, I acknowledge and agree that:

- I will be using my own Patient Portal account to access the patient's portal account.
- I will comply with the conditions outlined in the Patient Portal Information document.
- The patient can revoke my access to his/her Patient Portal account at any time

_____ _____
Proxy Signature **Date**

_____ _____
Patient Signature (if applicable) **Date**