

This form is an authorization that will permit RMC / RFH to release your medical information to certain designated adult individuals. This form must be completed by the adult patient who is authorizing another adult to access medical information in RMC's Patient Portal.

Please PRINT (except signature) and provide complete information in each section.

PATIENT INFORMATION			
Patient Full Legal Name	Date of Birth	Gender	
Complete Mailing Address	City	State	Zip Code
Telephone Number			

By signing this form, I am requesting the person(s) named below access to electronically view my RMC / RFH medical record via RMC's Patient Portal.

AUTHORIZED ADULT 1			
Full legal name of person	Telephone Number	DOB	Relationship to patient
Complete Mailing Address	City	State	Zip Code
Email address			

AUTHORIZED ADULT 2			
Full legal name of person	Telephone Number	DOB	Relationship to patient
Complete Mailing Address	City	State	Zip Code
Email address			

Please provide signatures on reverse side.



Patient Portal Adult - Adult Authorization

- This authorization is voluntary. I understand that I am not required to designate the person(s) above and I am not required to provide this authorization. I understand that RMC/RFH does not condition any of my healthcare treatment, evaluation, payment, or other services on whether I provide this authorization. I understand, however, that if I do not provide this authorization, RMC/RFH is not permitted to provide access to my RMC Patient Portal record to the person(s) listed above.
- I understand by signing this application, I am authorizing the person(s) listed above to electronically access and view my medical record via RMC Patient Portal. This form does not authorize release of my medical records by other methods or in other forms. I understand that all information made available in my RMC Patient Portal will also be made available to the authorized person(s) and RMC/RFH has no ability to limit the information viewed by the authorized person(s). Further, RMC/RFH has no control over what the authorized person does with the accessed information. I also acknowledge that: 1) the authorized person(s) may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations.
- I understand I may choose to revoke access at any time.
- If I choose to cancel this consent at a later date, I must send written notification to the Health Information Services Department, Regional Medical Center, 709 West Main Street, Manchester, IA 52057.
- If this consent is cancelled, I understand and acknowledge that information previously viewed by the above named person(s) would not be considered a breach of confidentiality.

This agreement and authorization will continue until cancelled by me or my healthcare power of attorney, if applicable, pursuant to the process described above. I understand that RMC / RFH reserves the right to revoke the access of the authorized person(s) at any time for any reason.

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Patient Signature

Date

OR

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Power of Attorney or Legal Guardian Signature

Date

*(Copy of completed Durable Power of Attorney for Healthcare or Legal Guardian appointment must be on file)

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Witness Signature

Return completed document to: Health Information Services Department
 Regional Medical Center
 709 West Main Street, PO Box 359
 Manchester, IA 52057



Patient Portal Adult - Adult Authorization