Authorization/Declination for Access to MyBothwellHealth Patient Portal
Bothwell Regional Health Center

Bothwell™
Regional Health Center

Patient Name	
Patient Date of Birth	
Patient Phone Number	
Patient Address	
Patient Email Address	
Is patient 13 or older	YES NO

I authorize the following individual to participate in Bothwell Regional Health Center's MyBothwellHealth as my proxy. **Both patient and proxy must sign below.

Proxy Name		
Proxy Date of Birth		
Proxy Phone Number		Relationship to Patient
Proxy Address		
Proxy Email Address		

- By signing this authorization, I am requesting Bothwell Regional Health Center to give access to my proxy to utilize the patient portal. I understand that my proxy will have the same access and privileges that I have for the patient portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Bothwell Regional Health Center continues to implement this product.
- This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.
- This authorization does not allow the release of any other content in my medical record other than what is accessible on the patient portal. If any other documentation is required the patient and/or legal representative must obtain proper authorization. Contact the Health Information Department at Bothwell Regional Health Center for more information if needed.
- **DECLINE PATIENT PORTAL ACCESS:** If you wish to decline patient portal access please check the box below.

☐ **I DECLINE ENROLLMENT AT THIS TIME TO "MY BOTHWELL HEALTH" ELECTRONIC PATIENT PORTAL**

I understand that by declining enrollment at this time, this will not keep me from enrolling at a later date.

_____ _____ _____

Signature of Patient (must sign if age 13 or older) **Date** **Time**

_____ _____ _____

Signature or Parent or Legal Guardian/Representative (if required) **Date** **Time**

_____ _____ _____

Signature of Proxy **Date** **Time**