BEACON HEALTH SYSTEM

Beacon Patient Portal Consent / Proxy

Application to enroll adult patient in or authorize proxy in Beacon Patient Portal Access

❑ Check here if you already have a Beacon Patient Portal account and are authorizing another person (proxy) to access your health information account.

❑ I am requesting access to Beacon Patient Portal to access my own information

Patient Information

Patient Name (Last, First Middle): _____ Date of Birth (mm/dd/yyyy):_____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

If requesting access for yourself, please provide a unique email address below (Print Legibly):

_____

Granting Access to Another Person (Proxy)

I would like to grant another person access to my Beacon Patient Portal for my online health information. Please review the following information. Initial each line to acknowledge that you received the information. Your proxy request will not be fulfilled if all lines are not acknowledged with your initials.

_____ Behavioral Health records (office notes, provider documents) will be sent to the Patient Portal except for Psychotherapy/Provider Counseling notes.
_____ Messages sent via the Patient Portal will be included in your permanent medical record and will be viewable to your designated proxy. You may want to avoid sending sensitive information in Messages since your Proxy will see them.
_____ You have the right to request that your provider keep your medical records private and NOT send sensitive information to the Portal that you do NOT want your proxy to see.
_____ I understand that Laboratory and Radiology results, which may contain sensitive information, will be in the Beacon Patient Portal and cannot be kept private.
_____ I understand that I may revoke access to my designated Proxy at any time by completing a Beacon Patient Portal Revocation form.

Name of person granted access: _____ Date of Birth:_____

Relationship to Patient: _____ Social Security Number:_____

Please provide an email address unique to this individual below (Print Legibly):

_____

Please Sign Below

_____ Date/Time: _____
Signature of Patient or Legal Representative (Required)

_____ _____
Printed Name of Legal Representative Relationship to Patient

When form is completed - You may return it to the Health Information Management (HIM) Department/Medical Records in the following ways:

In Person: At your provider's office, Registration, or the hospital Medical Records Department
Email: ReleaseOfInformation@BeaconHealthSystem.org
Fax: 574-647-1122 (ATTN: HIM)
For questions regarding enrolling in Patient Portal you may call: 574-647-7430