GVH GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
(215) 453-4850

MyGVH.org

Authorization for Proxy Access to GVH Patient Portal

(Please print)

Patient Name: _____

Date of Birth: _____

Address: _____

Medical Record # (if available) _____

I authorize the following individual to participate in Grand View Health's Patient Portal as my proxy.

Name of Delegate: _____

Email Address: _____
(Please supply the email address of the person who will be using 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 Grand View Health continues to implement this product.

I understand that patient information within the portal may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or human immunodeficieny virus (HIV) infection, Behavioral Health services/psychiatric care, or treatment for alcohol and/or drug abuse.

By signing this authorization, I am requesting Grand View Health to give access to my proxy to utilize the patient portal. I understand that Grand View Health will require my proxy to sign an acknowledgment and agree to Grand View Health's policies and procedures for use of the patient portal.

This authorization is valid until revoked by patient or proxy. I understand that a written request is necessary to revoke or cancel this authorization. I also 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 my be subject to re-disclosure and no longer protected by federal privacy laws.

I understand that any minors linked to my account will automatically be unlinked at age 14. To reestablish link, a new Patient Portal Enrollment Form will need to be filled out and submitted.

Patient Acknowledgment

_____ _____
Signature of Patient (under 14 years of age not required) Date

Proxy Acknowledgment

_____ _____
Signature of authorized representative (for minors and POA) Date

FOR STAFF USE ONLY

Patient name as shown in EMR: _____
Medical Record # as shown in EMR: _____
DOB as shown in EMR: _____
ID Verified by: _____
Enrollment completed by: _____
(Print Name)

- ☐ Patient Identification
- ☐ Photo ID
- ☐ POA Provided
- ☐ Office
- ☐ Patient Registration
- ☐ Health Information Management

Please present completed Authorization for Proxy Access Form to the Health Information Management Department with photo ID.