Pinehurst Medical Clinic

PATIENT AUTHORIZATON - Proxy Access to my Pinehurst Medical Clinic FollowMyHealth Account

(Friend or Family Member)

I authorize and request Pinehurst Medical Clinic to grant my authorized representative as designated below ("Authorized Representative") access to electronic protected health information, including clinical and guarantor billing information, maintained in my Pinehurst Medical Clinic's online Patient Portal record accessed through FollowMyHealth (hereafter referred to as "FollowMyHealth").

Authorized Representative (Printed Name):_____ **DOB:**_____

Relationship:_____ Email:_____

Address:_____ City:_____

Zip Code:_____ State:_____ Preferred Phone:_____ Cell ☐ Home ☐

Electronic Protected Health Information in my online chart may include but is not limited to:

Physican/Provider Notes	Diagnostic Test Results	Secure Messages
Diagnoses/Procedures	Medications/Allergies	Billing Information
Current Health Issues	Past Medical History	Social History

I understand that:

- Information in FollowMyHealth may include mental health, substance abuse or STD diagnosis, treatment or medications
- I may ***revoke*** this authorization at any time by contacting the Compliance Office at Pinehurst Medical Clinic at 1 (910) 235-5901. Such revocation shall not affect disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to ***redisclosure*** by my AuthorizedRepresentative and may no longer be protected by the HIPAA Privacy Rule.
- This authorization is voluntary. If I do not sign or if I revoke this authorization, Pinehurst Medical Clinic will still provide treatment to me and will seek payment for services provided.
- This authorization is valid unless and until I revoke the Authorized Representative's access.
- Access to my protected health information by my Authorized Representative requires that I maintain anactive online Patient Portal account.

Expiration:

I understand that by granting access to my Authorized Representative, they are required to agree to comply with Terms and Conditions required for online access. Should my Authorized Representative not accept and comply with the Terms and Conditions, I understand that Pinehurst Medical Clinic may deny my Authorized Representative access orrevoke their access to FollowMyHealth.

Signatures:

_____ _____

(Signature of Patient) *(Date Time)*

_____ _____ *xxx-xx-* ☐

(Printed Full Name of Patient) *(Date of Birth)* *(Last 4 digits of SSN)*

Witness Signature:_____ **Date Time:**_____

RETURN THIS FORM VIA FAX (910-235-3413) or MAIL to: Pinehurst Medical Clinic
Attention: Medical Records 45 Aviemore Drive Pinehurst, NC 28374