PATIENT PORTAL – HIPAA RELEASE & AUTHORIZATION FORM
FOR ANOTHER PERSON TO USE PATIENT PORTAL ON PATIENT'S BEHALF

Patient:

Name (print): _____

Email Address: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Last 4 Digits of SSN: _____ Telephone Number: _____

Portal Proxy (individual authorized by Patient to use and access the Shirley Ryan AbilityLab Patient Portal on behalf of Patient)

Name (print): _____

Email Address: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Last 4 Digits of SSN: _____ Telephone Number: _____

I, the undersigned Patient, authorize the release of information related to healthcare services I have received at Shirley Ryan AbilityLab to the Portal Proxy named above

I agree to allow the Portal Proxy to use and have online access to medical information about me that is currently available in the Patient Portal or becomes available in the Patient Portal as a result of future medical care.

Signature of Patient