CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

PATIENT PORTAL
PROXY ACCESS REQUEST AND CONSENT FORM

PATIENT NAME	DOB	DATE	
STREET ADDRESS	CITY	ST	ZIP
HOME PHONE	CELL PHONE		

PROXY INFORMATION
PLEASE COMPLETE THIS FORM IN ITS ENTIRETY TO GRANT ACCESS
Please Note – Proxy access to Patient Portal may take 3-5 days.

I authorize the Callier Center to grant the person named ("My Proxy") access as specified below to my Callier Center medical record available in the Patient Portal. A healow/Patient Portal account will be created for the person named ("My Proxy") once this form has been processed. Information should be accessed through the Callier Patient Portal.

PROXY INFORMATION
(Please print clearly)

PROXY NAME		DOB	
STREET ADDRESS	CITY	ST	ZIP
PHONE NUMBER	EMAIL ADDRESS		

PROXY ACCESS

FULL ACCESS -

□ Expiration Date: _____/_____/_____
□ Valid for as long as My Proxy is involved in my care

PATIENT AUTHORIZATION:

I understand and agree that:

- This Authorization is voluntary. I am not required to designate a Patient Portal proxy. My treatment will not be impacted, whether or not I sign this Authorization.
- This Authorization is valid for as long as specified above, unless I revoke/withdraw this Authorization. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the Callier Center.
- Once the Callier Center discloses health information as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by My Proxy.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse or other sensitive information.

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By signing below, I acknowledge that I have read, understand and agree to the terms stated above and the Terms and Conditions for Use related to the Callier Center Patient Portal.

SIGNATURE OF PATIENT **ONLY** DATE

PRINTED NAME OF PATIENT

If you are NOT the patient but are signing on behalf of the patient, please complete below.

I, _____, am the
(PRINT YOUR NAME)

(check which applies)

□ Parent with Parental Rights (applies only to minor children under 18)
□ Legal Guardian
□ Legally Appointed Healthcare Agent and the Patient is incapacitated
□ Medical Power of Attorney and the Patient is incapacitated

Representative's Signature: _____ Date: _____/_____/_____
(required)

Address: _____ Phone: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

Please return this form with any required documentation to:
1) Callier Center front desk at any location
2) FAX to ATTN: Medical Records at 972-883-3016
3) Mail to ATTN: Medical Records at either address listed below
Thank you!