JUPITER MEDICAL CENTER

Patient Portal Proxy Authorization

PATIENT INFORMATION

(minors under 18 years old or parents' access to minor patient portal via proxy setup is not available)

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

PROXY INFORMATION

Name: _____

Date of Birth: _____

Relationship to patient: _____
(documentation required if Medical POA, Legal Guardian, or other designated representative)

Address:_____

_____

Phone: _____

Please provide e-mail address for Jupiter Medical Center to notify the Proxy listed above with account activation and management instructions: _____

Proxy Acknowledgement: I certify that I have the relationship to the patient named above. I understand that the patient has granted me continued proxy access to his/her personal health information through their patient portal at https://www.jupitermed.com/myjupitermed/. I further understand that the patient may revoke this access at his/her discretion.

_____ _____

Proxy signature Date

Patient Authorization: I authorize Jupiter Medical Center to grant the "Proxy" listed above to have access to my online medical record information, including information that may become available as a result of future medical care. I understand that I may revoke this access at any time by notifying Jupiter Medical Center's Health Information Management (HIM) department in person or in writing.

_____ _____

Patient signature Date

Health Information Management
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