Stillwater Medical Center
CLINICS PATIENT PORTAL

Stillwater Medical Center
HOSPITAL PATIENT PORTAL

PROXY REQUEST

PHONE: 405.533.6010
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EMAIL: his-customerservice@stillwater-medical.org

To receive proxy access to the Stillwater Medical Patient Portals, you must complete this form and return it to the Health Information Services Department at Stillwater Medical Center. You will need to bring a government-issued photo ID and, if applicable, any legal documents granting legal representative status. Please complete one form for each patient.

PATIENT INFORMATION:

PATIENT NAME: LAST, FIRST, MIDDLE INITIAL	SEX:	DATE OF BIRTH	LAST 4 NUMBERS OF SSN:
STREET ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	MOBILE:	
EMAIL ADDRESS:			

DESIGNATED PROXY:

PROXY NAME: LAST, FIRST, MIDDLE INITIAL	SEX:	DATE OF BIRTH	LAST 4 NUMBERS OF SSN:
STREET ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	MOBILE:	
EMAIL ADDRESS:			
RELATIONSHIP TO PATIENT: ☐ Parent ☐ Legal Representative* ☐ Caregiver ☐ Other, please specify: _____			

I authorize Stillwater Medical to release my medical information contained within the Patient Portal to my Proxy. I understand:

- The Patient Portal contains limited medical information from my medical record and does not reflect the complete contents of my medical record.
- This form does not authorize the release of my medical record in any other method or form.
- Once my portal information has been disclosed to my Proxy, he/she may potentially re-disclose my portal information which will no longer be protected by federal privacy regulations or SMC.
- If my relationship with the Proxy changes, I must inform SMC immediately by written notice. Proxy access will remain in effect unless revoked.
- I may revoke this Proxy's access at any time by written notice to Stillwater Medical Center.
- My revocation will not affect any disclosures that were made prior to processing the revocation request.

PATIENT DESIGNATION [A Legal Representative of an incompetent, adult patient must sign here on behalf of the patient if a person other than such Legal Representative is designated as proxy for the patient.]: By signing below, I acknowledge I have read and understand the above statement and the attached Terms of Use. I agree to these terms and choose to designate the person named above as my Proxy allowing him/her access to my SMC Patient Portal account.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:	DATE:	TIME:
PRINTED NAME:	RELATIONSHIP TO PATIENT	

PROXY ACCEPTANCE: By signing below, I acknowledge I have read and understand the above statement and the attached Terms of Use. I agree to its terms.

PROXY SIGNATURE:	DATE:	TIME:
PRINTED NAME:	RELATIONSHIP TO PATIENT	

*Attach legal documents granting legal representative status -- guardianship appointment; power of attorney for healthcare decisions; or healthcare proxy appointment.