



**Citizens Memorial Hospital District
Citizens Memorial Health Care Foundation**

1500 N. Oakland Avenue, Bolivar, MO 65613
phone 417-326-6000 | fax 417-328-6338

citizensmemorial.com

Grant Proxy Request

The CMH Patient Portal provides online access to patient information, which may include problem list, allergies, medications, lab and radiology results, and other clinical documents. By using CMH Patient Portal this information can be accessed at your convenience. To grant proxy access to your CMH Patient Portal record, please complete the information below:

Patient Information

Name (last, first, middle initial) _____

Date of Birth _____ Phone _____

Email Address _____

Street Address _____

City _____ State _____ Zip _____

I grant proxy access to my CMH Patient Portal record to the following people:

Name (last, first, middle initial) _____

Email Address _____

Relationship to Patient _____ Phone _____

.....
Name (last, first, middle initial) _____

Email Address _____

Relationship to Patient _____ Phone _____

.....
Name (last, first, middle initial) _____

Email Address _____

Relationship to Patient _____ Phone _____

By signing below, I authorize the above named person(s) to review my electronic medical records maintained by Citizens Memorial Hospital District (CMH). I understand that this authorization allows the person named above to view my entire medical record of CMH via CMH Patient Portal. I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that any recipient to 42 CFR part 2 protected information must comply with part 2 protections and may not re-disclose the information except as permitted by part 2. 42 CFR §2.32.

I understand that my medical or billing record may contain information in reference to drug and/or alcohol treatment, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing, reproductive health, status and/or treatment, and/or other sensitive information, and I agree to its release. I understand that if I authorize the release of Drug and Alcohol Abuse treatment records that those records are protected by Federal Law.

Understandings & Agreements of Requestor

1. This authorization is voluntary.
2. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
3. I agree to waive all claims against the facility for the release of the requested information.
4. I understand that Citizens Memorial Healthcare cannot condition admission to the facility upon my providing this authorization.

By signing below, I acknowledge that I have read, understand and agree to the terms and agreements for granting access to my CMH Patient Portal account.

Signature of Patient _____ Date _____

Or

Signature of Legal Representative (or authorized person) _____

Relationship to Patient _____ Date _____

Please fax this form to 417-328-1110 or mail it to: CMH HIM Department, 1500 N. Oakland, Bolivar, MO 65613