Shirley Ryan Abilitylab

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 that becomes available in the Patient Portal as a result of future medical care.

I further understand and agree that:

- Along with other health information in my medical record, information (if any) may be disclosed about me regarding: HIV/AIDS; behavioral or mental health; sexually transmitted diseases (STDs); pregnancy; birth control; genetic testing; sexual assault/abuse; child abuse/neglect; and/or domestic abuse of an adult with a disability.
- Health information disclosed under this Authorization may be re-disclosed by my Portal Proxy to others.
- Communications on behalf of Patient must be sent from the Patient's record. Responses to the Patient will be posted in the Patient's record. Email alerts (if any) will be sent to the e-mail address on file in the Patient's record.
- This authorization is subject to revocation/withdrawal by the Patient at any time in writing to Shirley Ryan AbilityLab's Medical Records Department, except to the extent that action has already been taken to release this information.

_____ _____

Signature of Patient (or Patient's Legally Authorized Representative, if applicable) Date

_____

Relationship of Legally Authorized Representative to Patient (if applicable)

_____

Witness Signature (must be a third party who is neither the Patient nor the Proxy)

I, the Portal Proxy named above, have read and understood the terms of the Authorization above, and agree to use and access the Patient Portal on behalf of Patient in accordance with those terms, and only to the extent permitted by Patient/Patient's Legally Authorized Representative and authorized by law.

_____ _____

Signature of Patient's Portal Proxy Relationship to Patient

Please complete and return to Medical Records by fax at 312-238-2900 or by e-mail at *medical_records@sralab.org. You may also submit the completed form in person the next time you see your provider.