eCW Patient Portal Proxy Access Authorization Form

JIB Services, LLC / JIB Medical, PC

This form is an authorization to grant an individual proxy access to your eCW Patient Portal with JIB Medical, PC. The proxy you designate will have access to the medical information in your Patient Portal.

Patient Information	
Name:	Date of Birth:
Proxy Information	
Proxy Name:	Date of Birth:
Mailing Address:	Phone Number:
Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other:	

- I understand that I must renew my designee's portal proxy access or his/her access will automatically terminate.
- I understand that signing this authorization is voluntary and I am not required to authorize portal proxy access.
- I understand that the designated proxy I assign will have full access to the medical information in my Patient Portal including but not limited to treatment for drug or alcohol abuse, mental or behavioral health information or psychiatric care, sexually transmitted diseases, genetic testing information, and HIV/AIDS infection and/or related information. I specifically authorize the release of such information to my designated proxy through access to my Patient Portal. I understand that JIB Medical is not responsible for the redisclosure of my medical information accessed by my designated proxy, and if medical information disclosed to my designated proxy is re-disclosed by my designated proxy that released medical information may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time, for any reason by signing the revocation section of this form. Upon receipt and review by JIB Medical staff, my designated proxy's access will be terminated.

I acknowledge that I have read and understand the terms stated above, and I choose to designate the person named above as my portal proxy, thereby allowing them access to my medical information via the eCW Patient Portal.

AUTORIZING SIGNATURE

Signature: _____ Date: _____
(Patient or person authorized to sign)

Name/Authority to Sign:_____

NOTARY

This document must be notarized if submitted to JIB Medical by anyone other than the patient.

NOTARY SECTION

On this _____ day of _____ 20_____, before me personally appeared _____, who is known to me to be the patient who signed the above request.

_____ _____
Notary Public Signature *Date Signed*

Office Use Only: Received:_____/_____/_____ Staff Initials: _____

WRITTEN REVOCATION

***Proxy access can only be revoked by the authorizing signatory named above.**

By signing below, I hereby revoke my authorization to grant access to my eCW Patient Portal to the proxy listed above. The power and authority granted to my proxy is revoked and withdrawn and my signature below provides notice of such revocation. I understand that my revocation will not have effect on the actions taken prior to receipt of this revocation.

Signature: _____ Date:_____

Office Use Only: Received:_____/_____/_____ Staff Initials:_____