Adair County Health System
we surround you with care

Request for Electronic Access
To Health Information

Please allow 3 business days for processing

Please present this form at your clinic registration, hospital registration, or business office.
Or mail to ACHS Patient Portal | 609 SE Kent | Greenfield, IA 50849

Patient Information – PLEASE PRINT
Name
Phone
Date of Birth
Email
Last 4 digits of either SSN, DL or Ins Member #

For <u>Patient</u> Initiated Request:

I request electronic access to my health information at Adair County Health System. This authorization is voluntary.

_____ _____

Patient Signature Date

Proxy Information (Legal Guardian or Durable Power of Attorney)
Name
Phone
Date of Birth
Email
Last 4 digits of either SSN, DL or Ins Member #

For <u>Proxy</u> Initiated Request:

Relationship to Patient: (circle one) *Parent** *Durable Power of Attorney*** *Legal Guardian****

My signature represents that I have the legal right to this patient's health information. I understand that all proxy users may view messages and responses sent through the patient portal system.

_____ _____

Proxy Signature Date

For <u>Decline</u> of My ACHS Portal

My signature represents that I was offered electronic access to my health information at Adair County Health System and declined access.

_____ _____

Signature Date

For Adair County Health System Internal Use:

Received Date:	__Approved ___ Denied ___ Patient Declined	Processed Date:
Reviewed by:	Reason	Notes

*Parent Proxy: On the child's 18th birthday proxy access will end. Your child then may re-authorize your proxy access or you may provide legal documentation as proof of your right to access this information.

** & *** DPOA and Legal Guardian: You must provide a copy of legal documentation as proof of your right to access this information.