Peter J. Blodgett, DDS
John E. Wilmes, DDS
Lana W. McDermott, DDS

Proxy Authorization Form

Patient Name:	**Former Name(s):**
Date of Birth:	**Phone #:**
Address:	**City, State, Zip:**

I understand that authorizing proxy access will allow the person named below to access my Protected Health Information (PHI) OR the PHI of my minor child OR the PHI of an individual I am legally authorized to consent on their behalf (e.g., personal representative, legal guardian, activated POAHC). This authorization permits access to any care provided prior to the date of the authorization, as well as any care and treatment provided while the authorization is valid. I understand that the proxy will have access to the following information; this may include, but is not limited to:

- Test results - including laboratory and radiology
- Chart notes - including any information disclosed by the patient to our Dental and Administrative Staff
- Ability to communicate to our Dental and Administrative Staff regarding care and treatment
- Ability to review and request appointments
- Request renewals on prescriptions
- View summary information about medical history

The reason for this access authorization is for the proxy to play a more active role. I understand that activities and communications from the proxy may become part of the patient's permanent dental record. I understand that this authorization is optional/voluntary and that the provider has the right to revoke authorization for unauthorized or inappropriate actions made by the proxy. I understand that by inviting this person to access the record, I am providing West Side Dental documentation of my authorization for proxy access.

My Rights: 1) I have a right to receive a copy of this authorization after I sign it. **2)** I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment at West Side Dental. **3)** I have the right to revoke this authorization at any time by providing a verified, verbal statement of revocation to West Side Dental. **4)** I understand that the protected health information may be redisclosed by proxy and thus, no longer protected under the Privacy Rule. **5)** I have the right to inspect and receive copies of the PHI as permitted by law.

Having read this authorization, I hereby agree to abide by the terms of this agreement and grant proxy access to Protected Health Information (PHI) to the individual named below.

Proxy Name:	**Relationship:**
Proxy Date of Birth:	**Proxy Phone #:**
Proxy Address:	**City, State, Zip:**

*I understand that this proxy access **will not expire**, unless otherwise specified (*please check mark the time frame below, if applicable*):

Expiration Date:	☐ **6 months**	☐ **12 months**	☐ **18 Months**	☐ **24 months**

Signature of Patient (or Authorized Person):	**Date:**

Relationship/Authority of Authorized Person (if applicable**):**

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