Connect Patient Portal Proxy Access Authorization

Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement and risk management activities.

This form is an authorization to grant an individual portal proxy access to your Connect account. It will permit your designated proxy to access your medical information in your patient portal.

Patient Information

Name of Patient _____ Date of Birth ____/____/____

Street Address _____

City _____ State _____ Zip _____

Email _____ Phone Number _____

Portal Proxy Information – (Name of Person You Designate to Access your Patient Portal Account)

Name of Portal Proxy _____ Date of Birth ____/____/____

Email _____ Phone Number _____

Relationship to Patient ☐Parent/LAR of Minor ☐Spouse/Domestic Partner

☐Legal Representative ☐Other _____

Terms and Conditions:

- I understand that Connect is intended as a secure online source of medical information that contains a limited amount of information from my medical record and is not the complete record.
- I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure.
- I understand that use of Connect is voluntary and I am not required to authorize portal proxy access.
- I understand that if I share my Connect ID and password with another person, that person may be able to view my medical information or the medical information of any person who has authorized me as their Connect portal proxy.
- I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations.
- If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years.
- I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization, my designated portal proxy's access to my Connect Patient Portal account will be terminated.
- I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation.

I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy, thereby allowing them access to my medical information via Connect.

_____ _____ _____/_____/_____

Patient Printed Name Patient Signature Date