



St. Luke Community Healthcare

The **HEART** of the Mission Valley

REVOKE PROXY ACCESS TO PATIENT PORTAL FORM

Patient Name: _____

Date of Birth: _____ Phone: _____

Street Address _____ City/State: _____ Zip Code: _____

I request the following individual to be revoked as Proxy in St. Luke Community Healthcare Patient Portal.

Proxy Name: _____

Relationship to Patient: _____ Date of Birth: _____

By signing this authorization, I am requesting St. Luke Community Healthcare revoke the above named proxy from being able to access my Patient Portal. I understand that this revokes my Proxy online access to my personal health information. My Proxy will no longer be able to view information contained within my Patient Portal that I am able to view.

I understand that St. Luke Community Healthcare will revoke Proxy of this user to the Patient Portal and any use of my personal Patient Portal.

The previously signed authorization granting Proxy Access is no longer valid and is revoked by me. I understand that this written request is necessary to revoke or cancel this authorization. I understand that revocation will not be effective immediately but on the next business day. I realize that the information used and/or disclosed prior to this revoke Proxy request may be subject to re-disclosure and no longer protected by federal or Montana State privacy laws. I, in no way hold St. Luke Community Healthcare responsible for any information obtained by this Proxy prior to revoking the authorization.

Patient Acknowledgment

<i>Signature of Patient or Legal Representative</i>	<i>Relationship to Patient</i>	<i>Date</i>	<i>Time</i>

The signature must be notarized if not submitting form in person. Send notarized form to St. Luke Community Healthcare, HIM Department, 107 6th Ave. S.W. Ronan, MT 59864

State of _____ County of _____

This instrument was signed or acknowledged before me on _____ by _____
Month/day/year *Print name of signer*

Affix Seal/Stamp

Notary Public Signature

Verbal permission to revoke Proxy access has been obtained. A signed/notarized Revoke Proxy Access To Patient Portal Form must be forwarded to St. Luke Community Healthcare as soon as possible even if verbal permission has been obtained.

Name of person obtaining verbal permission _____ date _____ time _____ of the revocation