NORTHWELL HEALTH
EZACCESS PORTAL AUTHORIZATION FORM AND PROXY REQUEST
for ADULT PATIENT WITH LEGAL REPRESENTATIVE

This ezAccess Patient Portal Proxy allows an adult patient's Legal Representative to designate full or partial access to the patient's health information for themselves or another individual. Partial access allows the designated individual to view the patient's information, while full access includes the ability to communicate on the patient's behalf with their Northwell Health care team. The Patient's Legal Representative must complete this request form in order to receive proxy rights or grant them to a designated individual.

Section I. PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/____
LAST FIRST MI MM DD YYYY

AGE: _____ **GENDER:** ☐ M ☐ F **PHONE #** _____ ☐ Cell ☐ Home ☐ Work

HOME ADDRESS: _____
Street Address City State Zip

LEGAL REPRESENTATIVE (*must submit supporting documents*): **Legal Guardian** **Power of Attorney** **Other**

Representative Name: _____ **Date of Birth:** ____/____/____
LAST FIRST MI MM DD YYYY

Relationship to Patient: _____ **Phone #** _____ ☐ Cell ☐ Home ☐ Work

Home Address: _____
Street Address City State Zip

Section II. Proxy Information for Adult Patient

Name of Person being granted proxy _____ **Date of Birth** ____/____/____
LAST FIRST MI MM DD YYYY

Home Address: _____
Street Address City State Zip

Phone #: _____ ☐ Home ☐ Cell ☐ Work **Relationship to Patient:** _____

E-mail Address: _____ **Level of Access:** ☐ View Access Only ☐ Full Access

Patient or Legal Representative Authorization:

- I, as patient or Legal Representative, authorize Northwell Health to disclose my protected health information (PHI) to the ezAccess Patient Portal. This information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information.
- The information may include, and I specifically authorize release of, information relating to 1) Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection, 2) treatment for drug or alcohol abuse, 3) sexually transmitted diseases or 4) mental or behavioral health or psychiatric care.
- I understand that this Authorization will be in effect until such time as it has been revoked and that I may revoke this Authorization at any time by contacting the ezAccess Support line at (212) 614-0039 (option 3), or by writing to the provider at the address below. Revocation shall be effective except to the extent that action has already been taken based on this Authorization.
- I understand that signing this Authorization is voluntary. My treatment will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this Authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.

Proxy Designation

- I request that ezAccess send an electronic (e-mail) message and link to the person I have indicated herein as my proxy, inviting them to establish a linked account in the ezAccess Patient Portal in accordance with their policies and User Agreement. Once established, they will be able to view and access my health information, and, if "Full Access" is designated above, communicate regarding my care.
- I understand that I may cancel this designation at any time by contacting the ezAccess Support line at (212) 614-0039 (option 3), or by writing to the provider at the address below.

_____ _____
Patient (or Legal Representative) Signature Date

Proxy Acknowledgement

I acknowledge and agree that:

- I will establish my own ezAccess account in order to access the patient's ezAccess Personal Health Record (PHR) account. I will comply with the Terms and Conditions presented by ezAccess upon establishing my account.
- I understand that I will be granted the access indicated above and that this access can be cancelled or modified by the patient at any time.

_____ _____ _____
Portal Proxy Signature Relationship to Patient Date

When complete please mail or email (with documentation of guardianship or other legal representation status, if applicable) to: **Concorde Medical Group, NHPP** **316 East 30th Street, Floor 2, NY, NY 10016** **concordemedicalgroup@northwell.edu**

OFFICE USE ONLY
PATIENTS NAME: _____ **DOB** _____ **EPI/MRN #** _____
APPROVED: _____ **MANUAL INVITE SENT ON:** _____ **PROXY ACCOUNT CREATED ON:** _____
REJECTED: _____ **REASON FOR REJECTION:** _____