UNIVERSITY OF TENNESSEE MEDICAL CENTER
1924 Alcoa Highway ◆ Knoxville, TN 37920
(865) 305-9000

LABEL

IQHEALTH PATIENT PORTAL PROXY AUTHORIZATION

NAME:_____MR#:_____ENCOUNTER#:_____DATE:_____

I authorize the University of Tennessee Medical Center (UTMC) to allow the person(s) named below ("my Proxy") to have access to my patient portal. Information in my patient portal, which will be available to my Proxy upon completion of this Authorization, may include information related to mental health treatment, sexually transmitted diseases, HIV/AIDs, genetic testing, and records related to alcohol and substance abuse. **I understand that if there is information that I do not want my Proxy to see, then I should not sign this Authorization.**

I understand that once information has been disclosed to my Proxy, it may potentially be re-disclosed by my Proxy and the disclosed information may not be protected by state or federal privacy laws. I agree that UTMC and its agents are not responsible for my Proxy's use or publication of information accessed through my patient portal. I understand that authorizing my Proxy to have access to my patient portal is voluntary. I understand that I do not need to sign this Authorization to obtain treatment.

I understand that this Authorization will be good for **one year from this date** and must be renewed by me or my authorized representative. I understand that I may revoke this Authorization at any time and my Proxy's access to my patient portal will be terminated. I understand that I must do so in writing and give my revocation to the UTMC Medical Records Department. To begin the revocation process, call 305-9794. I understand that I am entitled to a copy of this Authorization.

Proxy Information

Name: _____
Address: _____
Relationship to patient _____
Date of Birth:_____
Email Address:_____

Name: _____
Address: _____
Relationship to patient _____
Date of Birth:_____
Email Address:_____

I understand and agree to the terms and conditions of this Authorization. By signing below, I designate the person(s) named above as my Proxy and allow my Proxy access to my UTMC patient portal.

_____ _____
Signature of Patient/Authorized Representative Date