Health Ministries Clinic
COMMUNITY HEALTH CENTER

REVOKE PROXY ACCESS REQUEST TO AUTHORIZATION

* This form must be completed to revoke proxy access to your portal *

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Last Name First Name Middle Initial MM/DD/YYYY

Address: _____
Number Street City State Zip Code

PROXY INFORMATION:

Revoke proxy access to the following individual(s) to my Health Ministries Clinic's portal.

Proxy Name: _____ Date of Birth: _____

Proxy Email address: _____

Proxy Name: _____ Date of Birth: _____

Proxy Email address: _____

By signing this authorization, I am requesting Health Ministries Clinic (HMC) revokes access to the above-named proxy from being able to access my Protected Health Information (PHI) through the 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 HMC's Portal that I am able to view.
- Health Ministries Clinic will revoke the proxy access of this user to the Portal and any use of my personal patient portal.
- The previously signed authorization, *Proxy Access Request and Authorization Form*, is no longer valid.
- I understand that this written request is necessary to revoke or cancel proxy access 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 revoked proxy authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

X_____ _____ _____
Signature of Patient, Parent/Legal Guardian if minor (Required) *Relationship to Patient (Required)* *Date (Required)*

BRING THIS FORM AND IDENTIFICATION IN PERSON UPON REQUEST