SOUTHWEST DIAGNOSTIC CENTER FOR MOLECULAR IMAGING™

SOUTHWEST™ DIAGNOSTIC IMAGING CENTER

ADULT PROXY FORM

Access to Another Adult's Patient Portal Record

To request access to the Patient Portal record of an adult whose medical care you help manage, please complete this form. The patient must also sign this form and provide authorization for release of medical information in the Patient Portal. Please note that the patient's chart will be accessed through your (the proxy's) Patient Portal record. Completing this form will establish a Patient Portal record for you and for the patient.

Please return forms to: Support Systems/Health Information Mgmt.
Southwest Diagnostic Imaging Center
8230 Walnut Hill Lane, Suite 100
Dallas, TX 75231
SWDICSupport@TexasHealth.org or Fax to: 214-345-6519

Your Information (All sections required – please print clearly.)

This section should be completed by the individual requesting access to another adult's Patient Portal record.

Name (Last, First, Middle Initial) ______________________________

Date of Birth: ______________ Email Address: ______________________

Gender: ______________ Relationship to Patient: ______________________

Street Address: ______________________ City: __________ State: ______ Zip: __________

Phone Number: ______________ Social Security Number (last 4 digits) XXX-XX-__________

Patient's Information (All sections required – please print clearly.)

Complete this section with information about the patient whose Patient Portal record you're requesting to access.

Name (Last, First, Middle Initial) ______________________________

Date of Birth: __________ Gender: ______ Email Address: ______________________

Street Address: ______________________ City: __________ State: ______ Zip: __________

Phone Number: ______________ Social Security Number (last 4 digits) XXX-XX-__________

Patient Portal Proxy Terms and Agreement

- I understand that this Patient Portal is intended as a secure online source of confidential medical information. My Patient Portal Login ID and Password cannot be shared with anyone, because that person will be able to view my health information and health information about someone who has authorized me as a Patient Portal Proxy. This action can result in revocation of my Patient Portal access.
- I understand my Patient Portal Login ID is my email address and that keeping my Login ID secure depends on two additional factors:

  1) It is imperative that this practice has my correct email address and that I inform them of any changes to my email address.

2) I also need to keep track of who has access to my email account so that only I, or someone I authorize, can see the messages I receive from this practice. I am responsible for protecting myself from unauthorized individuals learning my password. If I think someone has learned my password, I should promptly go to the website and change it.

- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that the Patient Portal contains selected, limited medical information from a patient's medical record.
- I understand that my activities within the Patient Portal may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to the Patient Portal is provided by Southwest Diagnostic Imaging Center (SWDIC) and Southwest Diagnostic Center for Molecular Imaging (SWDCMI) as a convenience to its patients and that SWDIC and SWDCMI has the right to deactivate access to the Patient Portal at any time for any reason. I understand that use of the Patient Portal is voluntary and I am not required to use the Patient Portal or to authorize a Patient Portal Proxy.
- By signing below, I acknowledge that I have read and understand this Patient Proxy Portal Authorization form and I agree to its terms.

Your (Proxy) Signature (Required) ____________________ Relationship to Patient ____________________ Date (Required) ____________________

Patient's Terms and Agreement

- I understand that the specified information to be released may include, but is not limited to, my personal diagnostic radiology exam reports and images, demographics, problem list, medical information, and billing statements.
- This person is my designated Patient Portal Proxy and I authorize release of this information only through my Patient Portal record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.
- I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy, and the disclosed information may not be covered by federal privacy protections.
- Participation in the Patient Portal and designating a Patient Portal Proxy is completely voluntary. I understand that I am not required to designate a proxy, and I am not required to provide this authorization.
- I understand that SWDIC and SWDCMI do not condition any of my health care treatment, payment, or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, SWDIC and SWDCMI are not permitted to provide access to my Patient Portal record to my designated proxy.
- I understand this authorization will not expire until I revoke it by providing a written request for revocation to SWDIC and/or SWDCMI. I understand that if I revoke this authorization, my designated proxy's access to my Patient Portal record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

Signature of Patient (Required) ____________________ Date (Required) ____________________