DO NOT WRITE IN MARGIN

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This form must be completed to revoke proxy access to your Patient Portal.

Patient Name: _____ Date of Birth:_____

Address: _____ Phone: _____

E-mail Address: _____

By completing and signing this form, I am requesting that my authorization for granting Proxy to my Patient Portal granted to _____ be revoked.

I understand that this revokes ONLY to the extent it has not been relied upon.

_____ _____ _____

Patient Signature Date Time

Return to:

Health Information Management
509 Biltmore Ave
Asheville, NC 28801
Patientconnect@msj.org

HIM Use ONLY:

Date of original authorization:

_____

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Mission Health

Revocation of Authorization for Proxy of Patient Portal