Proxy Account Authorization by Patient

Please complete this registration and return to your physician's front desk staff

Patient's First Name: ____

Patient's Last Name: ____

Email: ____

Date of Birth: _______________________ Telephone: _______________________________

Proxy relationship to the above patient: ____

Proxy First Name: ____

Proxy Last Name: ____

Proxy Email: ____

Proxy Address: ____

Proxy City, State and Zip code: ____

Proxy contact telephone number: ____

Check only one box:

☐ Authorization to *only* read information on FMH

☐ Authorization for all access on FMH

Check only one box:

☐ Requesting proxy access for a child (minor, under 17 years old)

☐ Requesting proxy access for a patient at the age of 18 or over

Patient's Signature: ___________________________________ Date: ______________________