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Patient Portal Signup Sheet

Parent → Name of individual requesting account: _____

Select Relationship:
- ❒ Self
- ❒ Spouse
- ❒ Parent
- ❒ Legal Guardian
- ❒ Other (Please describe): _____

Requestor's Home Address: _____

_____

Requestor's Phone Number: _____

Parent's → Requestor's Date of Birth: _____

Parent's → Requestor's Email Address: _____

Please Select a User Name: _____

(Case Sensitive – At Least 5 Characters – Letters and Numbers Only)

Please list the name of the individual whose medical record you are requesting access to.
(**A proxy authorization form may need to be completed**)

Child → Name: _____ DOB: _____

Child → Name: _____ DOB: _____

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Patient Portal Proxy Access Request, Authorization and Acceptance

Patient Name:		Patient's Date of Birth:	

Do you currently hold a MyAdvocareOnline.com account for your personal medical use? ☐ Yes ☐ No

Parent →

Proxy Name:			
Telephone #:		E-mail:	
Address:	Street		
	City, State, Zip		
	Apt/Suite		

Proxy Relationship to the Patient:

☐ Spouse ☐ Adult Child ☐ Family Member (specify: _____) Other: _____

Expiration Date/ Right of Revocation of Authorization:

This authorization will remain in effect unless revoked or terminated by the patient in writing to the Advocare Provider's Privacy Officer and/or other authorized representative.

REPRESENTATIONS AND WARRANTIES BY EACH, THE PATIENT AND THE PROXY:

- I will not share my confidential log-in credentials with anyone else for use within the Patient Portal;
- I understand that MyAdvocarOnline.com is not to be used in emergency situations. If there is a medical emergency or an urgent medical question, I will call 911 or contact an Advocare Provider directly;
- As the Proxy, I have read and understood the requirements for accessing the above named Patient's MyAdvocareOnline account information and agree to abide by the according terms and conditions. My signature represents that all of the information provided about me is correct;
- I understand that this authorization pertains to records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed;
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my account will not be granted to the Proxy;
- Neither Advocare, LLC nor its management company, Continuum Health Alliance, LLC, are liable for any unauthorized access to your health information that may result from you and your Proxy not protecting your access credentials.

By signing below, I confirm all of the representations and warranties above, and as the Patient, hereby authorize my Proxy to have full access to my medical information, and if the Proxy, hereby accept the duties and responsibilities of being granted access to the Patient's medical information.

_____ _____

Patient Signature (or Legal Guardian, if patient minor or incapacitated) Date

_____ _____

Proxy Signature Date
(Parent)