

Patient Information

Full Name _____ Date of Birth _____
Email Address _____ Social Security Number: XXX-XX-_____ (last 4 digits)
Address _____
Day Phone # _____ Cell # _____ City _____ State _____ Zip _____

I request the following individual to be revoked as my Proxy in the TRMC Patient Portal:

Proxy Information

Full Name _____ Date of Birth _____
Email Address _____ Social Security Number: XXX-XX-_____ (last 4 digits)
Relationship to Patient _____ I have my own personal TRMC Patient Portal account: Yes No
Address _____
Day Phone # _____ Cell # _____ City _____ State _____ Zip _____

Acknowledgement

- By signing this authorization, I am requesting TRMC revoke the above-named proxy from being able to access my TRMC Patient Portal. I understand that this revokes my proxy's online access to my personal health information. My proxy will no longer be able to view information contained within my TRMC Patient Portal.
- I understand that TRMC will revoke the proxy access of this user to my TRMC Patient Portal and any use of my personal patient portal.
- The previously signed authorization granting Proxy Access is no longer valid and is revoked by me. I understand that this written request is necessary to revoke or cancel this authorization. However, 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.

Signature and PRINTED Name of Patient/Legal Representative (include relationship to patient) Date

BRING PAPERWORK AND A FORM OF IDENTIFICATION IN PERSON TO:

Telluride Regional Medical Center
500 West Pacific Ave Telluride, CO

Office Use Only:

Photo ID verified: _____
Date received: _____
Date completed: _____