**PROXY ACCESS - ONLINE SERVICES ACCESS (18+ years)**

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| **PATIENT** | |
| Name: | D.O.B: |
| Address: | |
| Contact Numbers: | |
| Reason for Proxy Access: | |
| By signing this document you are permitting the below person to have full access to your online services which may contain sensitive private information. | |
| Signature of Patient: | Date: |

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| **PROXY ACCESS** | |
| Name: | D.O.B: |
| Relationship to patient: | |

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| **FOR RECEPTION USE ONLY**  I have seen patients ID (please not type of ID presented): **Y**  Name of Employee: Date:  Signature of Employee: |