





Connect Patient Portal Proxy Access Authorization

Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement and risk management activities.

This form is an authorization to grant an individual portal proxy access to your Connect account. It will permit your designated proxy to access your medical information in your patient portal.

Name of Patient Date of Birth / / Street Address City State Zip Phone Number Portal Proxy Information – (Name of Person You Designate to Access your Patient Portal Account) Name of Portal Proxy Date of Birth / / Email Phone Number Relationship to Patient Parent/LAR of Minor Spouse/Domestic Partner Legal Representative Other Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's porter proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect.	Patient Information			
Email Phone Number Portal Proxy Information – (Name of Person You Designate to Access your Patient Portal Account) Name of Portal Proxy Date of Birth / / Email Phone Number Relationship to Patient Parent/LAR of Minor Spouse/Domestic Partner Legal Representative Other Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect.	Name of Patient		Date of Birth	/
Portal Proxy Information — (Name of Person You Designate to Access your Patient Portal Account) Name of Portal Proxy	Street Address			
Portal Proxy Information – (Name of Person You Designate to Access your Patient Portal Account) Name of Portal Proxy	City		State	Zip
Name of Portal Proxy Email Phone Number Relationship to Patient Parent/LAR of Minor Spouse/Domestic Partner Legal Representative Other Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's porta proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect.	Email		Phone Number	·
Relationship to Patient Parent/LAR of Minor Spouse/Domestic Partner Legal Representative Other Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect.	Portal Proxy Informati	on – (Name of Person You	Designate to Access your	Patient Portal Account)
Relationship to Patient Parent/LAR of Minor Other Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect.	Name of Portal Proxy		Date of Birth	/ /
Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect.	Email		Phone Number	
 Terms and Conditions: I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect. 	Relationship to Patient	☐ Parent/LAR of Minor	☐Spouse/Domestic Partne	er
 I understand that Connect is intended as a secure online source of medical information that contains a limite amount of information from my medical record and is not the complete record. I understand that this authorization is voluntary and my treatment will not be conditioned upon my authorization of this disclosure. I understand that use of Connect is voluntary and I am not required to authorize portal proxy access. I understand that if I share my Connect ID and password with another person, that person may be able to vie my medical information or the medical information of any person who has authorized me as their Connect portal proxy. I authorize the OHCA and their entities to use and disclose my health information and I understand if this information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations. If I am an adolescent patient between the ages of 12-18, I understand that I must renew my designee's portal proxy access every two (2) years. I understand that this authorization is valid until I revoke in writing to the OHCA. If I revoke this authorization my designated portal proxy's access to my Connect Patient Portal account will be terminated. I understand that my revocation will not have effect on the actions taken prior to receipt of the revocation. I acknowledge that I have read and understand the terms stated within this Connect Patient Portal Proxy Access Authorization. I agree to the terms and choose to designate the person named above as my Connect Portal Proxy thereby allowing them access to my medical information via Connect. 		☐ Legal Representative	□Other	
	 I understand that if I my medical informat portal proxy. I authorize the OHCA information is re-disc privacy regulations. If I am an adolescent proxy access every to I understand that thi my designated porta I understand that my I acknowledge that I have Authorization. I agree to a second proxy. 	share my Connect ID and passion or the medical information and their entities to use and closed by the recipient, the relevant between the ages of two (2) years. I proxy's access to my Connect revocation will not have effect the terms and choose to design to the terms and choose to design to my Connect the terms and choose to design to my Connect the terms and choose to design the terms and choose to design to my Connect the terms and choose to design to my Connect the terms and choose to design the terms and choose to design the terms and choose to design the my Connect the terms and choose to design the terms are the terms and choose to design the terms are the terms and the terms are the terms are the terms are the terms and the terms are the terms	sword with another person, to of any person who has authorized disclose my health information eased information may no located that I must be evoke in writing to the OHCA to Patient Portal account will be to on the actions taken prior to the stated within this Connect gnate the person named above	hat person may be able to view norized me as their Connect on and I understand if this inger be protected by federal ast renew my designee's portal a. If I revoke this authorization, be terminated. It receipt of the revocation.
	Patient Printed Name	Patient	Signature	/