ADULT OR MINOR PROXY REVOCATION FORM

Please complete this form only if you would like to revoke or cancel your proxys' access to your medical records through the My Health Onsite (MHO) Patient Portal.

PATIENT INFORMATION

Name: _____ **Date of Birth:** ____/____/____ (mm/dd/yyyy)

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Email: _____ **Phone:** _____

Last 4 Digits of SSN*: _____ **Gender:** ❑ Male ❑ Female

*Required for authentication purposes.

PROXY INFORMATION

Name: _____ **Date of Birth:** ____/____/____ (mm/dd/yyyy)

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Email: _____ **Phone:** _____

Relationship to Patient: _____

Last 4 Digits of SSN*: _____ **Gender:** ❑ Male ❑ Female

*Required for authentication purposes.

By signing this Adult or Minor Proxy Revocation Form, I am requesting that My Health Onsite revoke/cancel my proxys' access to my medical records in the My Health Onsite Patient Portal.

X _____ _____

Patient Signature **Date**

X _____ _____

MHO Staff Member Signature **Date**