BUTLER MEMORIAL HOSPITAL

My BHS Health Proxy Access: Expiration/Removal Form

Note: There will be one Form signed for each Proxy

Patient Information:

Patient Name: _ **Date of Birth:** _ _ _ _ _ _ _ _ _ _

Last First M.I

Medical Record Number:_____ **Social Security Number:** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(Optional) **(Optional)**

I previously requested that the individual below have access to My BHS Health Records as my proxy. I now want to discontinue that access so that My BHS Health Record is no longer able to be viewed over the internet by my previous proxy listed below.

I understand that this will only stop access to records following the date my request to remove access is processed. I understand that Butler Health System (BHS) may take five business (5) days from receipt of my completed written request to process the expiration and remove the access by my proxy.

I understand that the information disclosed pursuant to my proxy authorization(s) may be re-disclosed by the proxy and is therefore no longer protected by federal or Pennsylvania State privacy laws. I agree not to hold Butler Health System or its affiliates, or their respective physicians, employees or agents responsible for any such re-disclosure by my proxy.

_____

Print Name of Patient

_____ **Date:**_ _ _ _ _ _ _ _ _ _

Signature of Patient

_____

Print name of proxy who will NO LONGER have access to My Record

Proxy email address (if known):_____