DEARBORN COUNTY HOSPITAL

DCH Patient Portal PROXY Registration Form

Please fill out this form as completely as possible. If you do not know your Medical Record Number, leave the field blank. **You must present this form along with photo identification in order to register a proxy.**

Your Name _____

Social Security Number_____ Date of Birth_____

Address _____

City _____ State _____ ZIP_____

Phone _____ Email Address_____

Today's Date _____

Medical Record Number_____

Proxy (Who are you giving access to):

Proxy Name _____

Relationship to Patient_____

Address _____

City _____ State _____ZIP _____

Phone _____Email Address _____

Patients who permit proxy access of their records do so at their own risk. Proxy access may be terminated by the patient at any time, without proxy consent, by contacting the Patient Portal help line at 812-537-8488.

Your Signature: _____

Date: _____