



YAKIMA INTEGRATIVE HEALTH  
<https://www.yakimaintegrativehealth.com/>  
 307 S 12 Ave, Ste. 9 Yakima, WA 98902  
 Phone: (509) 469-2483 | Fax: (509) 469-8870

## ONLINE PORTAL PROXY ACCESS

A proxy is a person who has been given permission to access the patient’s online Athena account and medical information. Proxy access can be given by consent to the following:

- Anyone an adult patient permits to be a proxy (e.g., a spouse)
- A parent/legal guardian of a minor (please note full proxy access will expire when patient becomes 13 years of age)
- A parent/legal guardian of a developmentally disabled minor or adult patient

### Proxy of Patient Information

Proxy Name (Last, First M.I.)		Maiden name		
Date of Birth	Email			
Street Address		City	St	Zip
Home Phone	Cell Phone		Work Phone	
Preferred Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone				
Do we have consent to send automated phone calls and text alerts? <input type="checkbox"/> Phone calls only <input type="checkbox"/> Text alerts only <input type="checkbox"/> Both				

**Proxy of Patient may have access to:** (Please check one of the following)

- Full patient record, including billing
- Billing only

## MY RIGHTS

I understand that I can withdraw this consent form at any time. The way to withdraw is to inform the front office, preferably with a signed letter acknowledging withdrawal of consent. I understand this withdrawal will not affect any actions or reports already made by Yakima Integrative Health (YIH) providers and staff. It will not affect YIH using the information to bill for services.

Once consent is given to disclose your information to your proxy, the recipient may re-disclose your information and privacy laws may no longer protect your information. Federal and state laws forbid reporting about drug and alcohol abuse treatment, sexually transmitted diseases, or mental health issues without the written consent of the patient, or by law.

I understand I do not have to sign this authorization to get health care benefits (treatment, payment, or enrollment).

\_\_\_\_\_  
 Patient or Legally authorized individual signature

\_\_\_\_\_  
 Date Time

\_\_\_\_\_  
 Printed Name if signed on behalf of the patient

\_\_\_\_\_  
 Relationship (parent, legal guardian, representative)