Beth Israel Deaconess Hospital
Milton • Needham • Plymouth
MySite

PATIENT PORTAL
THIRD PARTY ACCESS REVOCATION FORM

Patient Name: _____ **Date of Birth:** _____
Last First M.I.
Address: _____
Street Address City, State Zip Code
Telephone #: _____ **Medical Record #:** _____ **Social Security #:**_____
Last 4 digits
Provider Name (if known): _____

Revocation of Third Party Access: (Person whose access will be revoked)

Patient Name: _____ **Date of Birth:** _____
Last First M.I.

Email Address: _____ **Relationship to Patient?** _____

Are you filling out this form for yourself or for a patient that you are the parent, guardian or health care proxy of? ____ Self ____Guardian/Parent _____HCP (if you are a guardian or health care proxy, please supply supporting paperwork)

Are you over 18 years old? Yes ____ No _____

If no, are you an emancipated minor? Yes _____ No ____ (If yes, please provide proof of emancipation)

By signing this MySite Third Party Access Revocation Form, I understand that I am giving my permission to Beth Israel Deaconess Hospitals of Milton, Needham, and Plymouth to revoke access to my health portal and medical information from the above documented individual. I understand that revocation will not be effective immediately but on the next business day. I realize that the information used and/or disclosed prior to this revoked proxy authorization may be subject to re-disclosure and no longer protected by federal privacy laws. I, in no way, hold Beth Israel Deaconess Hospitals of Milton, Needham and Plymouth responsible for any information obtained by this third party prior to revoking authorization.

Patient/Parent or Health Care Proxy/Surrogate/Legal Guardian: By signing below, I hereby authorize Beth Israel Deaconess Hospitals of Milton, Needham and Plymouth to revoke access to the individual listed in Section II so that my protected health information can no longer be viewed by him/her:

X _____ _____ _____

Patient, Parent, Health Care Proxy/Surrogate or Legal Guardian Signature (Required) | Relationship to Patient (Required) | Date (Required)

Beth Israel Deaconess Hospitals use only:

Individual Who Received Request: _____ Date Request Received:_____

Medical Record Number / Account Number:_____

Individual Completing the Request: _____ Date Request Completed:_____