Capital Health

Authorized Representative to Access the Patient Portal

Patients may grant authorized representatives access to their Patient Portal at Capital Health. The authorized representative will be able to view your information within the Patient Portal. This could include sensitive information relating to substance abuse (including alcohol/drug abuse), mental health and HIV/AIDS related information (including test results), but not limited too.

Patient's First Name:_____ Patient's Last Name:_____
DOB:_____ Email Address:_____

Street Address:_____
City:_____State:_____Zip:_____

Authorized Representative Information

First Name:_____ Last Name:_____
DOB:_____ Email Address:_____

Street Address:_____
City:_____State:_____Zip:_____

Relationship:_____ Home Phone Number:_____

Mobile Phone Number:_____ Work Phone Number:_____

I hereby designate the following individual as an authorized representative for the purpose of accessing my patient portal account. By signing this document, I am acknowledging that I have read and understand the information above and I am granting this authorized representative to have access to my personal health information from the patient portal. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. This authorized representative is effective as of the date below and will be in effect unless revoked by me. I understand that I may revoke this authorized representative at any time by completing the "Cancellation of Prior Authorized Representative to Access the Patient Portal" form.

_____	_____	_____
Signature of Patient	Date	Time
_____	_____	_____
Signature of Witness	Date	Time

Every effort will be made to process this request within ten (10) business days.

Mail your completed form to:

Capital Health
One Capital Way
Pennington, NJ 08534
Attn: Health Information Management

Or Fax your completed form to:

609-303-4093

**********Internal Usage**********

Dated Completed:_____ Processed By (Name):_____