

Access to another adult's Iris record

To request access to the Iris record of an adult whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for the release of medical information in Iris. Please note that the patient's chart will be accessed through your (the proxy's) Iris record. Completing this form will establish an Iris record for you and the patient.

Your information (all section required – please print clearly)

This section should be completed by the individual requesting access to another adult's Iris record.

Name: *(last, first, middle initial)* _____ Date of birth : _____
Last 4 digits SSN: _____ E-mail: _____
Street address: _____ City: _____ State: _____ Zip: _____
Phone number: _____

Patient's information (all section required – please print clearly)

Complete this section with information about the patient whose Iris record you're requesting to access.

Name: *(last, first, middle initial)* _____ Date of birth : _____
Last 4 digits SSN: _____ E-mail: _____
Street address: _____ City: _____ State: _____ Zip: _____
Phone number: _____

▶ _____
Your (proxy) signature **Relationship to patient** **Date (required)**

I acknowledge that I have read and understand this Iris adult proxy form. I agree to its terms and choose to designate the person named above as my Iris proxy, thereby allowing them access to my Iris medical record.

▶ _____
Signature of Patient (or authorized person) (required) **Relationship to patient** **Date (required)**

