Tri-Area Community Health

REVOKE PROXY ACCESS FORM

PATIENT Information: (Complete all information. Please print clearly.)

Name: (First, Middle Initial, Last) _____

Date of Birth: _____ Last 4 digits of PATIENT's Social Security No: _____

Telephone Number: _____ Mobile Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

PATIENT's Primary Care Provider: _____

PROXY ACCESS TO BE REVOKED:

PROXY Information: (Complete all information. Please print clearly.)

Name: (First, Middle Initial, Last) _____

Date of Birth: _____ Last 4 digits of PATIENT's Social Security No: _____

Telephone Number: _____ Mobile Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

By signing below, I acknowledge that I am revoking the proxy access to the above-named individual thus stopping all portal access to my information. Please note it can take approximately 24 hours for the change to be effective.

Date: _____ Printed Name: _____

Signature: _____

(Please note that parents of minors cannot remove another parent due to divorce or custody issues alone, please see Virginia State Code §20-124.6. Court orders need to be produced prior to the removal of a parent's access.)