INTEGRIS HEALTH

Request to Revoke Proxy Access to INTEGRIS & Me Record

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I am requesting that INTEGRIS Health revoke proxy access to my INTEGRIS & Me record for:

☐ Proxy Name (*person(s) who can access*): _____

_____

☐ All proxies who have access to my INTEGRIS & Me record

I understand the proxy named above will no longer be able to view my information in the INTEGRIS & Me patient portal after this request is processed.

I understand that revocation will not be effective immediately and I should allow 2-3 business days for processing.

I understand this revocation will not affect any disclosures that were made prior to processing this revocation request.

Patient Signature (or authorized person):	Date:
Printed Name:	Relationship to Patient:

If person other than the patient signs, indicate authority to sign for patient and attach documentation

The completed form may be faxed to INTEGRIS Health Information Management at 405-552-8773,
mailed to 3433 NW 56th Street, Bld. B Ste. C50 Oklahoma City, OK 73112, or
emailed to Healthinfomanagement@integrishealth.org. For questions, call 877-778-7211

Patient Label
Patient Name:
MRN:
DOB: