Request to Revoke Proxy Access to INTEGRIS & Me Record

Patient Name: ______________________________ Date of Birth: ______________
Address: ______________________________ Last 4 SSN: ______________
______________________________ Phone: ______________

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

---

FOR INTEGRIS HEALTH USE ONLY

Signature Verification:

☐ Verified by ID (Driver's license, State ID, Military ID)
☐ Form signed in person
☐ Signature on file

Signature Verified By:	Date:

Send to Health Information Management Department for Processing
Phone: 877-778-7211
Fax: 405-552-8705

Patient Label
Patient Name:
MRN:
DOB:

INT-5345
Release of Information Forms