MyHealth Proxy Access Request & Authorization

PATIENT LABEL HERE

Patient Name: ____ **DOB:** _____/_____/_____ **Phone:** (________)__________________

Patient Email (14 years or older): ____

PERSON REQUESTING MYHEALTH ACCESS (PROXY)

"Proxy" is an adult that is being granted access to a patient's MyHealth account (usually a parent or legal guardian.) If a patient is 14 years or older, they must authorize proxy access. Proxy access for patients 18 years & older with intellectual disability require documentation showing you are the patient's legal guardian or healthcare representative. Proxy access can be revoked at any time.

Proxy Name: ____ **DOB:** ____/____/____ **Primary Phone:** (________)____________________

Proxy Email: ____ Social Security#: _____________________________________

Address: ____
Street City State Zip

MYHEALTH ACCESS REQUESTED (check one)

- ❑ Parent/Legal Guardian requesting access of minor child 13 years and younger… ***(Access is automatically revoked at 14 years old)***
- ❑ Parent/Legal Guardian requesting access of teen 14-17 years… **(*Patient's authorization is required below*)**
- ❑ Adult requesting access of adult patient 18 years & older… **(*Patient's authorization is required below*)**
- ❑ Request access of teen 14-17 years, with intellectual disability… **(*Legal documentation or* Provider auth required*)**
- ❑ Request access of adult patient 18 years & older, with intellectual disability… **(*Legal documentation is required*)**

CONSENT & SIGNATURE

<u>I have read & agree to the following:</u> **(1)** This agreement does not affect patient's ability to obtain healthcare services; **(2)** MyHealth access can be revoked at any time; **(3)** Any actions taken in MyHealth may become part of the patient's permanent medical record; **(4)** MyHealth may not reflect complete medical records; **(5)** Proxy may access all medical records unless patient requests otherwise at the time of service. This may include, but is not limited to, HIV test results and/or diagnosis; mental or behavioral health diagnosis and/or treatment; genetic testing information; other sexually transmitted disease test results and/or diagnosis; and drug/alcohol diagnosis, treatment, or referral information; **(6)** Federal law may restrict re-disclosure of protected health information. Once disclosed, it may potentially be redisclosed by Proxy & privacy laws may not protect your information.

X____ ____________________________ _____/_____/_____
Signature of Parent / Legal Guardian **Relationship to Patient** **Date Signed**

X____ ____________________________ _____/_____/_____
Signature of <u>PATIENT</u> (Required if 14 years or older) **Patient Name (printed)** **Date Signed**

OFFICE USE ONLY

❑ Parent/Legal Guardian accessing child under 18 yrs ❑ Adult accessing adult patient ❑ Intellectual disability (provider authorized)

*Provider Name (printed): ________________________ Provider Signature:: _________________________ Date: _____/_____/_____

Access activated on _____/_____/_____ by (staff name printed): ______________________________________