HAYSMED

# Patient Portal Proxy Access Request
# Adult Patient

PAWNEE VALLEY COMMUNITY HOSPITAL
HAYSMED PARTNER

**Granting proxy access to your medical information in the Patient Portal:**

- A proxy is a person who can access your Patient Portal account information as if they were you.
- A spouse, caregiver, parent, child, or legal guardian may be granted full access to your Patient Portal account with proxy access.
- This form must be completed for an adult proxy (18 or over) to view information in the Patient Portal.
- Authorization for proxy access to an adult patient's account is valid until revoked by the patient, death, or any statutory or regulatory requirement automatically allows the authorization to expire.
- Adults with diminished capacity may have their legal guardian request proxy access.

**ADULT PATIENT INFORMATION** *(patient for which proxy access is requested)*

First Name:_____ Last Name:_____ Sex: ❑ M ❑ F

Date of Birth:_____ Last 4 Digits of your Social Security #:_____

Address:_____

Previous Names (if applicable):_____ Phone #:_____

**ADULT PROXY INFORMATION** *(parent, spouse, caregiver, etc., wishing to access patient information by proxy)*

First Name:_____ Last Name:_____ Sex: ❑ M ❑ F

Date of Birth:_____ Last 4 Digits of your Social Security #:_____

Address:_____

Previous Names (if applicable):_____

Phone #:_____ Email Address:_____

Does the proxy already have a portal account? ❑ Yes ❑ No Relationship to Patient:_____

**Authorization to Release Protected Health Information in the Patient Portal**

*To be completed by the adult patient.*

**I authorize HaysMed and/or Pawnee Valley Community Hospital to release my medical information via the Patient Portal to the designated proxy named above.**

- The following information is to be released: All information as allowed through the Patient Portal (note: the Patient Portal may not contain the complete medical record).
- I understand that I have a right to revoke this authorization at any time by signing the Proxy Revocation form.
- I understand that the information in my health record may include information relating to reproductive concerns, sexually transmitted infections, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize the release of these records.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re−disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 785−623−5824.
- I understand this authorization must be filled out completely and signed, dated, and timed in order to be considered valid. My authorization may also be provided over the phone. Completion of this request will be completed within three (3) business days. I understand that I may be contacted by a staff member to verify this information.
- I represent that I am eighteen (18) years of age or older, or legally emancipated, and have the legal authority to sign this authorization.

_____ _____ _____

Signature of Patient/Authorized Person | Date/Time | Relationship to Patient

***If the requestor is not the patient, please complete:*** _____ _____

Printed Name of Requestor | Phone Number

**If patient is not signing this authorization, a copy of legal documentation verifying the relationship of the proxy to the patient must be provided.**

| **For Office Use Only:** | |
|---|---|
| ❑ Verbal consent obtained via phone<br>by Associate:_____<br>Date/Time: _____<br>Date Enrolled:_____<br>Initials: _____ | |