Presence Health℠

Presence Health Patient Portal Proxy Access Request and Authorization

Patient Information

Patient Name:_____
Last First Middle Initial

Addresses:_____
Street Address City, State Zip Code

Phone Number:_____ Date of Birth:_____ SSN #:_____

Email Address:_____

This form is an Authorization that will permit the person named on the reverse side of this form (your proxy) to have access to the information about you in your patient portal. Please read it carefully. All of your medical information that is available in your patient portal will be available to your proxy if you sign this Authorization. Patient portals include information related to mental health treatment, sexually transmitted diseases, HIV/AIDs, genetic testing, and incidental records related to alcohol and substance abuse.

<u>If there is information that you do not want your proxy to see, then you should not sign this Authorization</u>.

Health information to be accessed: All information contained in my patient portal medical record.

Purpose of portal access: To allow my patient portal proxy to view my medical information.

I authorize the release of my patient portal medical information to my proxy through proxy access to my patient portal account. This Authorization does not authorize the release of my medical information by other methods or other formats. I understand that once information has been disclosed, it may potentially be re-disclosed by my proxy and the disclosed information may not be protected by state or federal privacy laws. I understand that authorizing Presence Health and my physician to disclose my medical information to my proxy via the patient portal is voluntary. I understand that Presence Health will not condition healthcare treatment or payment for treatment upon my signing this Authorization. Presence Health and my physician are not receiving any remuneration from any third parties because of this Authorization.

You may revoke this authorization at any time by submitting a written request to revoke proxy access to your physician's office and/or your hospital's Health Information Management Department.

For minors, the authorization is valid until your 18th birthday unless you submit a written request to revoke proxy access to your physician's office and/or your hospital's Health Information Management Department.

I understand that a revocation is not effective for uses and disclosures of my medical information that have already been made or other actions that have been taken in reliance on this Authorization or as required by law. I understand that I am entitled to a copy of this Authorization and that I may review a copy of Presence Health's and my physician's Notice of Privacy Practices at any time by visiting http://www.presencehealth.org/privacy-policy or contacting my physician's office.
I acknowledge and agree that I will comply with all requirements listed on the Presence Health Patient Portal Terms and Conditions of Use Agreement and this document.

X _____ _____ _____
Patient signature required for patients age 12 and over or Parent or Legal Guardian signature under age 12 | Relationship to Patient (Required) | Date (Required)

X _____ _____ _____
Witness Printed Name (Required) | Witness Signature (Required) | Date (Required)

<u>SEE REVERSE FOR PROXY SELECTION AND SIGNATURE</u>

Proxy Information

Proxy Name:_____
Last First Middle Initial

Address:_____
Street Address City, State Zip Code

Phone Number:_____ Date of Birth:_____ SSN #:_____

Email Address:_____

Proxy-Access Request
Check the best description of the preferred proxy access

Adult Patient	**Minor Patient**
Access to another adult's patient portal information: This section also applies to emancipated minors who have provided proof of emancipation. **Select One** My relationship to the patient is: ___ Adult-Capable Adult Patient The patient must sign this form to provide authorization for release of patient-portal information. **Authorization for Proxy access is valid until revoked in writing by the patient**. ___ Legal Guardian of or Health Care Agent for an Adult Patient Select the option that best describes the relationship: ___ Legal guardian ___ Power of attorney for health care If you are the legal guardian or an agent under a health care power of attorney, you must provide a copy of the guardianship letters of office or executed healthcare power of attorney verifying your authority to have access to the patient's medical information. You must notify Presence Health of any changes in that authority.	Access to a minor child's patient portal information: Individuals requesting Proxy access must have parental or legal guardianship rights. My relationship to the minor is: ___ Parent ___ Legal guardian of the patient. Requires attachment of guardianship letters of office verifying the Proxy's status as patient's legal guardian. **Select one** ___ Adult-Minor Patient ***(*****Age 0-11*****)*** You will be granted full access to your child's record until the patient reaches the age of 12. When the patient reaches the age of **12**, parental or guardian access will automatically be turned off. ___ Adult-Minor Patient (**Age 12-17**) Parental access to the records of a patient age 12 to 17 is permitted only with the written consent of the child. **Authorization for Proxy access given between the ages of 12 and 17 is valid until revoked by the patient in writing or until the patient turns 18.**

Proxy Signature
By signing below, I acknowledge and agree that I:

- Will use my own patient portal account to access the patient's patient portal information
- Will comply with all usage requirements defined on the Presence Health Patient Portal Terms and Conditions of Use Agreement
- Understand the patient (ages 12 and above) can revoke my access to his/her patient portal account at any time

X _____ _____ _____
Proxy (Required) Relationship to Patient (Required) Date (Required)