

Follow *My*Health Patient Portal Proxy Access

Patient Portal Proxy Access Request and Authorization Form for Mountain Area Health Education Center, Inc. (MAHEC)

FOR OFFICE USE ONLY:

PROXY

Front office review by: _____ on _____

MR# _____

MR review by _____ on _____

Invite sent by _____ on _____

ALL INFORMATION IN THIS BOX IS REQUIRED TO PROCESS YOUR PROXY AUTHORIZATION

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Last First M.I.

Address: _____
Street Address City, State Zip Code

PROXY INFORMATION: (person to whom you authorize MAHEC to release the Patient Portal record)

Proxy Name: _____ Date of Birth: _____
Last First M.I.

Address: _____ Phone Number: _____
Street Address City, State Zip Code

Email address: _____

Please check one of the boxes below that best describes the proxy access requested. (Please note that for all types of proxy access, the patient's chart will be accessed through the proxy's FollowMyHealth Patient Portal account.)

ADULT PATIENT

Access to another adult's Patient Portal record.

*(Note: This section also applies to Emancipated Minors.
Emancipated Minors must provide proof of emancipation.)*

Relationship of Proxy to Adult Patient is:

☐ Other Adult:

- The patient should sign this form to provide authorization for release of their medical information to the proxy listed above via the MAHEC Patient Portal.
- Authorization for proxy access is valid until revoked by patient.

☐ **Legal Representative of Adult Patient:** (Adults who have a surrogate relationship with another adult through a legal arrangement.) **Select the option below that best describes this representative relationship:**

☐ Legal Guardian (court order)

☐ Power of Attorney for Health Care (with current authority)

- If you are the legal guardian or you have current decision-making authority under a Power of Attorney for Healthcare for this patient, this request must be accompanied by a copy of the legal paperwork verifying your authority to have access to the patient's medical information.
- You must notify MAHEC immediately in case of any change in authority.

☐ Other (specify) _____

MINOR PATIENT

Access to your minor child's Patient Portal record.

Individuals requesting access must have parental rights or be the court appointed legal guardian for the minor patient.

My Relationship to the Child is:

☐ Parent

☐ Legal Guardian of the Patient *(Must attach a copy of the court order appointing you as the minor patient's legal guardian)*

Patient Authorization:

- By signing this proxy request, I understand that I am giving my permission for MAHEC to disclose my protected health information (PHI) through the Patient Portal to my proxy which may include sensitive information such as treatment for pregnancy, drug/alcohol abuse, mental health, HIV status, genetic testing and labs, if applicable.
- This proxy request is effective until my Patient Portal account is inactivated or I revoke proxy access.
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that are created after the date this form is signed.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or North Carolina privacy laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Patient Portal account will not be granted.

By signing below, proxy acknowledges and agrees that:

- I will be using my own FollowMyHealth Patient Portal account to access the patient's Patient Portal account.
- As indicated, I have parental rights or legal guardianship rights to access this patient's record.
- I have not been denied periods of physical placement with the patient and there are no court orders or restraining orders in effect limiting my access to this patient's medical records and/or information.
- Communications on behalf of the patient through the Patient Portal must be sent from the patient's record and responses will be received in the patient's record. Patient Portal e-mail alerts will be sent to the e-mail address entered under "Proxy Information."
- For a child age 0-17 years, I will be granted full access to the Child's medical record, subject to NC law.

Legal Guardians:

Any documents, if any, I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expires, I must immediately notify MAHEC in writing of the change in authority and mail it to the Health Information Management Department.

Patient Signature: By signing below, I acknowledge and agree that I will comply with the terms and conditions contained in this document and understand that I can revoke this proxy access at any time by notifying MAHEC in writing (only sign on one applicable line).

I am an **Adult Patient/Emancipated Minor** Authorizing Proxy Access to my account:

X _____
Patient Signature (Required) Date (Required)

I am the **Parent/Legal Guardian** of the Patient Authorizing Proxy Access to his/her account:

X _____
Parent or Legal Guardian Signature (Required) Relationship to Patient (Required) Date (Required)

Proxy Signature: By signing below, I acknowledge and agree that I will be using my own FollowMyHealth Patient Portal account to access the patient's Patient Portal account. I will comply with the terms and conditions contained in this document and understand the patient can revoke my access to his/her Patient Portal account at any time.

I am the **Individual/Proxy** receiving access to the Patient's account:

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