PATIENT PORTAL PROXY - Adult

A proxy is able to access the patient's protected health information maintained within the *FollowMyHealth* portal.

Patient Information:

First Name, Middle Initial and Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Phone Number: (____) _____

Proxy Information:

First Name, Middle Initial and Last Name: _____

Street Address: _____

City: _____ State: _____ Zip:

Date of Birth: ____/____/____ Phone Number: (____) _____

E-Mail Address: _____

Relationship to Patient: _____

Type of Access (circle one): Read only Update

Proxy Information:

For Adult to Adult proxy where the patient can make his/her own health care decisions, both the patient and the proxy must complete page 2.

For Adult to Adult proxy where the patient cannot make his/her own health care decisions, the Legal Guardian or Durable Power of Attorney for Healthcare must complete page 3.

Patient can make his/her own healthcare decisions:

Proxy:

1. I must present my photo ID for identity verification.
2. The patient can revoke my access to his/her *FollowMyHealth* account at any time.
3. I will comply with the Terms of Service on the *FollowMyHealth* website.

By signing below, I acknowledge that I have read and understand the information above and I agree to these terms.

Proxy Signature:_____ Date:_____

Patient:

1. I must present my photo ID for identity verification.
2. I authorize the ability to view my health information on the *FollowMyHealth* portal to the proxy identified above.
3. I understand that the information on the *FollowMyHealth* portal may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, sexually transmitted diseases, HIV/AIDS test results, developmental disabilities and also the ability to view genetic testing results.
4. I understand that I have a right to revoke authorization to view my *FollowMyHealth* portal at any time. I may revoke access by sending an email to followmyhealth@uhsi.org or calling (262) 656-3344.
5. I understand that the proxy may further disclose my health information.
6. I will comply with the Terms of Service on the *FollowMyHealth* website if I choose to have my own access to the portal.

By signing below, I acknowledge that I have read and understand the information listed above and I agree to these terms.

Patient Signature:_____ Date:_____

FOR OFFICE USE:

I have verified or completed the following:

1. The authorization form has been properly completed by the correct parties.
2. The patient & proxy have signed the form.
3. I have viewed the photo ID to confirm the identity of the patient and the proxy.

Form has been sent to DL_Follow_My_Health Yes / No

Print Name:_____ Title: _____

Signature:_____ Date / Time:_____

Patient cannot make his/her own healthcare decisions:

My relationship to the Patient is as follows:

☐ Permanent Legal Guardian - In addition to showing photo ID, proxy must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the proxy's status as permanent legal guardian.

☐ Activated Durable Power of Attorney for Healthcare (DPOA) - In addition to showing photo ID, proxy must attach a copy of the valid Durable Power of Attorney for Healthcare and two Physician Certifications verifying the patient lacks decisional capacity.

I acknowledge and agree to the following:

1. I must present my photo ID for identity verification.
2. I will comply with the Terms of Service on the *FollowMyHealth* website.
3. I have the proper documentation authorizing me as a legal representative for this patient, thereby allowing me access to his/her health information through the *FollowMyHealth* portal.
4. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired; I must immediately notify United Hospital System of the revocation, termination or expiration. If written, this notification must be dropped off at or sent to **Health Information Management Department, United Hospital System, 6308 8th Avenue, Kenosha, WI 53143.** I may also opt to call in my notification at 262-656-2283.
5. My access to this patient's *FollowMyHealth* health information will expire three years from the signature date of this document. I will then need to complete this form again to obtain access for another three years.

By signing below, I acknowledge that I have read and understand the information listed above and I agree to these terms.

Proxy Signature:_____ Date:_____

FOR OFFICE USE:

I have verified or completed the following:

1. The authorization form has been properly completed by the correct parties.
2. The proxy has checked the correct box and signed the form.
3. I have viewed the photo ID to confirm the identity of the authorized representative/proxy.
4. For Guardian/Attorney or DPOA, the correct paperwork has been presented and a copy is available and will be attached to this document.

Form has been sent to DL_Follow_My_Health Yes / No

Print Name:_____ Title: _____

Signature:_____ Date / Time:_____

* LD - 0 1 5 *

UNITED HOSPITAL SYSTEM

Proxy Request Form