ADULT PROXY ACCESS FORM

(Adult proxy access to the Your Account Patient Portal for an adult 18 years of age or older)

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (____)_____

Email: _____

Last 4 Digits of SSN*: _____ Gender: ___ Female ___ Male

**Required for authentication purposes*

PROXY INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (____)_____

Email: _____

Relationship to Patient:

_____

Last 4 Digits of SSN (or entire SSN if not a patient of AHS)*: _____

**Required for authentication purposes*

ACCESS GUIDELINES

- For patients 18 years of age or older.
- Only one proxy per patient account.
- Proxy access may be terminated at any time by the patient online or by written request.
- Patient or proxy requestor may drop off the completed form to the patient's primary site location of Adventist Health System.
- Requests are processed within 3-5 business days upon receipt.

Patient Signature: _____ Date: _____

Adult Proxy Signature: _____ Date: _____

MyAccess PATIENT PORTAL AUTHORIZATION FORM

I am requesting that (insert name of proxy)_____receive access to my health information that is available in the MyAccess Patient Portal. This person is designated as my proxy for the MyAccess Patient Portal. I authorize Adventist Health System to provide proxy access to the health information contained in the MyAccess Patient Portal to my designated proxy. I understand that the medical information in the MyAccess Patient Portal is obtained from my electronic medical record and may include information from all Adventist Health System facilities.

I understand that the MyAccess Patient Portal may also contain sensitive information such as, but not limited to, mental health, HIV/AIDS, genetic information, sexual assault information, tuberculosis, and venereal disease. I authorize Adventist Health System to provide proxy access to my sensitive information to my designated proxy.

I understand that once information has been disclosed, it potentially may be redisclosed by the proxy and the disclosed information is not covered by federal privacy protections.

Participation in the MyAccess Patient Portal is voluntary. I understand that Adventist Health System does not condition any of my health care treatment, payment or other services on whether I provide this authorization.

This authorization will expire upon revocation, or on the date or event specified here _____. I also may revoke this authorization at any time by providing a written request for revocation to Adventist Health System. I understand that if I revoke this authorization, my designated proxy's access to MyAccess will end. I also understand that my revocation will not affect any disclosures that were made prior to processing the revocation request.

Patient Signature: _____ Date: _____

Adult Proxy Signature: _____ Date: _____