Adult Proxy Form

MyUHealthChart.com

Access to Another Adult's MyUHealthChart Record

To request access to the MyUHealthChart record of an adult whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyUHealthChart on the "Adult Proxy Authorization Form." Please note that the patient's medical information will be accessed through your (the proxy's) MyUHealthChart record. Completing this form will establish a MyUHealthChart record for you and for the patient.

Please return all forms to University of Miami Health System workforce member.

Your (Proxy) Information *(All sections required – please print clearly.)*

This section should be completed by the individual requesting access to another adult's MyUHealthChart record.

Name (*last, first, middle initial*) _____ Date of Birth _____

Last four digits of Social Security Number:_____ Email:_____

Street Address: _____ City:_____ State: _____ Zip:_____

Phone Number: _____

Please check your relationship to Patient: □ Parent
□ Legal Guardian** □ Durable Power of Attorney for Healthcare** □ Caregiver □ Other (specify) _____

*** If you are the legal guardian or if you have a durable power of attorney for healthcare with regard to the patient, then this request **MUST** be accompanied by a copy of legal paperwork verifying your authority to have access to the patient's medical information (for example: a court order appointing you the guardian, durable power of attorney for health care, etc). If you are a caregiver, family member or friend of the patient who is not incapacitated, then the patient needs to sign this Form and the Adult Proxy Authorization for Release of Medical Information Form.*

Patient's Information *(All sections required – please print clearly.)*

Complete this section with information about the patient whose MyUHealthChart record you're requesting to access.

Name (*last, first, middle initial*) _____ Date of Birth _____

Last four digits of Social Security Number:_____ Email:_____

Street Address: _____ City:_____ State: _____ Zip:_____

Phone Number: _____

MyUHealthChart Terms and Agreement

- I understand that MyUHealthChart is intended as a secure online source of confidential medical information. If I share my MyUHealthChart ID and password with another person, that person may be able to view my health information and health information about someone who has authorized me as a MyUHealthChart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyUHealthChart contains selected, limited medical information from a patient's medical record and that MyUHealthChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's clinic.
- I understand that my activities within MyUHealthChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to MyUHealthChart is provided by University of Miami as a convenience to its patients and that University of Miami has the right to deactivate access to MyUHealthChart at any time in its sole discretion and for any reason.
- I understand that use of MyUHealthChart is voluntary and I am not required to use MyUHealthChart or to authorize a MyUHealthChart proxy.
- By signing below, I acknowledge that I have read and understand this MyUHealthChart Sign-Up Form and I agree to its terms. I also agree to abide by the terms and conditions on the MyUHealthChart site.
- My access to the patient's medical information in MyUHealthChart will be terminated when my power of attorney, legal guardianship, or authorization rights expire or are revoked.
- **I understand that MyUHealthChart is not to be used in an emergency.**
- I understand that Communications on behalf of the patient must be sent from the patient's record and responses will be received in the patient's record. MyUHealthChart email alerts will be sent to the email address entered in the patient's record.
- I hereby certify that the information provided above is true and correct.

Your (Proxy) Signature *(Required)* **Relationship to Patient** *(Required)* **Date** *(Required)*

I acknowledge that I have read and understand this MyUHealthChart Sign-up form. I agree to its terms and choose to designate the person named above as my MyUHealthChart Proxy, thereby allowing them access to my MyUHealthChart medical record.

Signature of Patient **Relationship to Patient** **Date**
(or authorized representative, such as legal guardian or power of attorney)

Adult Proxy Authorization for Release of Medical Information

MyUHealthChart.com

This form is an authorization that will permit University of Miami to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyUHealthChart record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their MyUHealthChart record as a proxy. If you do not have an Adult Proxy Form, please contact your clinic, or download one from www.MyUHealthChart.com Frequently Asked Questions (FAQ's) page.

(All sections of the form are required – please print clearly.)

Patient Name (*last, first, middle initial*) _____

Date of Birth _____

Last four digits of Social Security Number:_____ Email:_____

Street Address: _____ City:_____ State: _____ Zip:_____

Phone Number:_____

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in MyUHealthChart Record. This person is my designated MyUHealthChart proxy. I authorize University of Miami to release the health information contained in my MyUHealthChart record to my MyUHealthChart proxy. I understand that the medical information in MyUHealthChart is obtained from my electronic medical record and may include information from all facilities listed in University of Miami's Notice of Privacy Practices. I authorize release of any information contained in my MyUHealthChart held by University of Miami to my designated proxy. The information that may be used or disclosed, if available in MyUHealthChart, may include but is not limited to: lab results, visit summaries, and communications with my healthcare providers. I understand and acknowledge that this may include information regarding the following:

- HIV/AIDS status- HIV related information, which includes any information indicating that I have had an HIV related test, or HIV infection, HIV related illness or AIDS, or any information which would indicate that I have been potentially exposed to HIV;
- Sexually transmitted diseases;
- Sexual assault information;
- Mental health treatment records (including mental health records relating to involuntary or voluntary mental health treatment.
- Substance abuse (drug and alcohol) treatment records.

I authorize release of this information only through my MyUHealthChart record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

The purpose of this authorization for release of my information through MyUHealthChart is _____ _____. [The statement "at my request" is a sufficient description of the purpose when you initiate the authorization and do not elect to provide a statement of the purpose].

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

Participation in MyUHealthChart and designating a MyUHealthChart proxy is completely voluntary. I understand that I am not required to designate a MyUHealthChart proxy and I am not required to provide this authorization. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, enrollment or my eligibility for benefits. However, I also understand that if I do not provide authorization, University of Miami is not permitted to provide access to my MyUHealthChart record to my designated proxy.

This authorization will expire on _____. I understand that if an expiration date is not included, proxy access will remain in effect until revoked or terminated. I understand that I may revoke this authorization at any time via the MyUHealthChart patient portal or by making a written request to the University of Miami Privacy Office P.O. Box 019132 (M-879), Miami, FL 33101, privacy@med.miami.edu. I understand that if I revoke this authorization, my designated proxy's access to my information via MyUHealthChart will be terminated. I also understand that revoking this authorization will not affect any access or disclosure that has already taken place prior to processing the revocation request.

Signature of Patient (or authorized person)	**Printed Name**	**Date**

If person other than the patient signs, indicate person's authority to sign for patient (e.g., guardian) and attach documentation:

_____

NOTE: Authorization expires on the date you listed above or one year from the date of signature. A new *MyUHealthChart Proxy Authorization Form* must be submitted after expiration to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time online through MyUHealthChart or by providing a written request to your healthcare provider.