MY MH CHART Patient Portal
PROXY Authorization

Please PRINT demographic information as clearly as possible.
The accuracy of this information helps ensure the correct person is provided with authorization to access your Methodist Hospital Patient Portal.

PATIENT INFORMATION

LAST NAME:_____**FIRST NAME:**_____**Middle Initial:**_____
Date of Birth:____/___/____ **Phone:** (___)_____ **Medical Record #:**_____

Address 1: _____ _____ _____ _____
Mailing Address **City** **State** **ZIP CODE**

ACCESS by PROXY Information

(The person authorized to access the Patient 's health care information with Methodist Hospital.)

LAST NAME:_____**FIRST NAME:**_____**Middle Initial:**_____

Date of Birth:____/___/____ **Gender:** ☐ **M** ☐ **F** **Preferred Language:**_____

Address 1: _____ _____ _____ _____
Mailing Address **City** **State** **ZIP CODE**

Phone: (____)_____ (_____)_____ **Email:**_____@_____
Home **Cell**

Does you Proxy have an active Patient Portal account with Methodist Hospital? ☐**No** ☐**Yes MR #?**_____

Has the Proxy been a patient at Methodist Hospital in the past? ☐**No** ☐**Yes**

ADULT

Access to another adult's electronic health record.

□ This section also applies to **Emancipated Minors**
(Copy of proof of Emancipation must be attached to this form.)

☐ **Adult-capable Adult**

The Patient must sign this form to provide authorization for release of their medical information.

- Authorization for proxy access is valid until revoked by the patient.

☐ **Guardian of Adult**

Mark category of Guardianship:

□ Legal Guardian; court ordered
□Power of Attorney for
□ Healthcare
□ Other: _____
Copy of legal document verifying your authority/guardianship must be attached to this authorization release.

MINOR/CHILD

Access to a minor child's Patient Portal Information.
My relationship t the child is:
□ PARENT
□ Permanent Legal Guardian of the Patient
(Copy of Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal Guardian of the Minor/Child must be attached to this form)

NEWBORN—17 Years Old

You will be authorized to full access to your child's health care information with Methodist Hospital until the child turns 18.

- If you have also been a patient with Methodist Hospital, your child's record will be accessible through your Patient Portal access point.

To Be Completed By The Patient

Who is authorizing additional access to their healthcare information at Methodist Hospital. *(Does not apply to Legal Guardian, Power of Attorney, or Newborn to 17 years old.*

To Be Completed By The Proxy

REMINDER: Copy of any legal documents must be attached to this form when submitted for processing.

Incomplete forms will not be accepted.

AUTHORIZATION FOR ACCESS

To my personal PATIENT PORTAL

- By signing this proxy request, I understand that I am giving my permission for Community United Methodist Hospital, dba Methodist Hospital and/or Methodist Hospital Union County, to disclose my protected health information (PHI) through the Patient Portal to my proxy. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information.
- This proxy request is effective until my Patient Portal account is inactivated or proxy access is revoked or
  □ expires on: _____
- 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 Kentucky State 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, parents acknowledge and agree:

- I will be using my own Patient Portal account at Methodist Hospital to access the Child's Patient Portal account.
- I have parental rights or legal guardianship rights to access this Child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records, and/or information.
- Communications on behalf of the Child through the Patient Portal must be sent from the Child's record and responses will be received in the Child's records. Patient Portal email alerts will be sent to the email address entered under Parent/Legal Guardian ("Proxy") information.
- For a child age zero to 18 years, I will be granted full access to the Child's Patient Portal record.

LEGAL GUARDIANS:

All documents, if any, I have provided in support of my request 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 expired, I must immediately notify Methodist Hospital in wiring of the change in authority and the date it became effective, and mail it to Methodist Hospital Attn: Health Information Management P.O. Box 48 Henderson, KY 42419-0048

Adult Patient/Legal Guardian/Parent

By signing below, I acknowledge and agree to comply with the terms and conditions on the Patient Portal Terms and Conditions and this document.

X_____

Patient, Parent or Legal Guardian Signature (REQUIRED)

_____

Relationship to Patient

Date: _____

Proxy

By signing below, I acknowledge, agree and understand:

- I will be using my own Patient Portal account to access the patient's Patient Portal account.
- I will comply with the Patient Portal Terms and Conditions
- The patient can revoke my access to his/her Patient Portal account at any time.

X_____

Proxy Signature (Required)

_____

Relationship to Patient (Required)

Date: _____