

MYHEALTH

PATIENT PORTAL PROXY Authorization

PATIENT Information: Please **PRINT** information as clearly as possible. **Incomplete forms will not be accepted**

LAST Name: _____ FIRST Name: _____ MIDDLE Initial: _____
 Date of Birth: ____/____/____ Gender: Male Female Last 4 of SSN: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Other: (____) _____
 Address: _____
 Mailing Address City State Zip Code

PROXY Information: *(The person authorized to access the PATIENT's healthcare information in MYHEALTH Patient Portal)*

LAST Name: _____ FIRST Name: _____ MIDDLE Initial: _____
 Date of Birth: ____/____/____ Gender: Male Female Last 4 of SSN: _____
 Address: _____
 Mailing Address City State Zip Code
 Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
 Primary Email: _____@_____ Preferred Contact Method: Email Phone

ADULT		CHILD/MINOR	
Access to another adult's electronic health record. <input type="checkbox"/> This section also applies to Emancipated Minors (Copy of proof of Emancipation must be attached to this form)		Access to a minor child's Patient Portal information. My relationship to the child is: <input type="checkbox"/> Parent <input type="checkbox"/> Permanent Legal Guardian of the Patient <i>(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)</i>	
<input type="checkbox"/> Adult-capable Adult	<input type="checkbox"/> Guardian of Adult	<input type="checkbox"/> Newborn - 12 years old	<input type="checkbox"/> Minors 13 - 17 years old
The Patient must sign this form to provide authorization for proxy access of their medical information. <ul style="list-style-type: none"> Authorization for proxy access is valid until revoked by the Patient. 	Mark category of Guardianship: <input type="checkbox"/> Legal Guardian; court ordered <input type="checkbox"/> Power of Attorney for <input type="checkbox"/> Healthcare <input type="checkbox"/> Other: _____ Copy of legal document verifying your authority or guardianship must be attached to this Authorization. You must notify MYHEALTH Support IMMEDIATELY in the event your authority/guardianship status changes for this Patient.	You will be authorized to full access to your child's health care information with MYHEALTH until the child turns 13 years old. <ul style="list-style-type: none"> If you have also been a patient with Pomona Valley Hospital your child's record will be accessible through your MYHEALTH Patient Portal access point. When the Patient turns 13 years old, by state law, they can choose whether parent or guardian can access to their MYHEALTH Patient Portal. If continued access is desired by both Patient and Proxy, a new Proxy Authorization form can be completed. 	Patients 13 - 17 years old can choose to permit whether their parent(s) or guardian(s) are authorized to access portions of their health care information specially protected under state laws; this includes reproductive, STD, mental health and substance abuse information. <ul style="list-style-type: none"> When the Patient becomes 18 years old, parent/guardian access to their MYHEALTH Patient Portal will be disconnected. If continued access is desired, a new Proxy Authorization form can be completed after they turn 18 years old.



To be completed by the PATIENT who is authorizing additional access to their health information in the MYHEALTH Patient Portal. (Does not apply to Legal Guardian, Power of Attorney, or Newborn through 12 years old)

AUTHORIZATION for ACCESS
to my personal PATIENT PORTAL

- By signing this proxy request, I understand that I am giving my permission for Pomona Valley Hospital Medical Center to disclose my protected health information (PHI) through the MYHEALTH Patient Portal to my designated proxy. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, etc.
- The information available to my proxy may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request is effective until my Patient Portal account is deactivated or proxy access is revoked.
- 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 California 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 the MYHEALTH Patient Portal account will not be granted for my designated proxy.

Patient / Legal Guardian / Parent

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

REQUIRED Patient/Parent/Legal Guardian Signature Date

REQUIRED Relationship to Patient

For MYHEALTH Staff Use Date: _____

Valid ID Verified Photo Id Gov't ID Other: _____

Presented appropriate legal documents: Yes No

Receiving Staff Signature Date

To be completed by the PROXY

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

By signing below, parents acknowledge and agree:

- I will be using my own MYHEALTH Patient Portal account 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 MYHEALTH Patient Portal must be sent from the Child's record and responses will be received in the Child's record. Patient Portal e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") Information.
- For a child newborn through 12 years, I will be granted full access to the Child's MYHEALTH record. **On the Child's 13th birthday**, I will no longer have access to the Child's Patient Portal record unless the child authorizes me to access any specially protected information - mental health, reproductive services, HIV and AIDS and chemical dependency.

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 Pomona Valley Hospital Medical Center in writing of the change in authority & the date it became effective, and mail it to:

Pomona Valley Hospital Medical Center
ATTN: Health Information Management – MYHEALTH
1798 N. Garey Ave. Pomona, CA 91767

Proxy

By signing below, I acknowledge, agree & 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 MYHEALTH Patient Portal account at any time

REQUIRED Patient/Parent/Legal Guardian Signature Date

REQUIRED Relationship to Patient

