NEWMAN
REGIONAL HEALTH

Adult Proxy Access to My Health Info Patient Portal

Requirements and Procedures:

Proxy access for adult patients allows another person, of the patient's choosing, to link the patient's My Health Info patient portal account to their own patient portal account. Linking the patient's portal account to their own will allow the proxy to view and manage the personal health information of the patient.

Requirements for Proxy online access to a patient's record:

- Individual requesting access must have a signed consent from the patient
- Adult Proxy Access Authorization Form must be completed and signed
- Each delegate requesting proxy access must have their own My Health Info account

I understand that:

- I must have a My Health Info account
- I must log-in to My Health Info with my own User ID and Password
- I agree to abide by the terms and conditions of the My Health Info site
- My Health Info is not to be used in emergency situations. If I have a medical emergency or have an urgent medical question, I will call 911 or contact my health care provider directly.

Adult proxy access to a patient's record will be revoked upon the patient's written request. Newman Regional Health reserves the right to revoke online access to medical information at any time.

Communications and requests on behalf of the patient must be sent from the patient's record; responses will be posted in the patient's My Health Info account. My Health Info email alerts will be sent to the email address entered in the patient's record.

You will be granted access to the record only after the completed Adult Proxy Access to My Health Info Patient Portal Authorization Form is received.

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Patient Portal Authorization Form

Please enter the **Delegate's** information below:

Delegate Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Relationship to Patient:_____

Do you (delegate) have an active My Health Info Account? Yes ☐ No ☐

I acknowledge that I have read and understand the requirements and procedures for accessing this patient's My Health Info account and medical record online. I certify that I am a delegate of the patient listed below and that all of the information I have provided is correct. I hereby request access to this patient's online My Health Info account and medical record. This authorization is valid until it is revoked or expires.

_____ _____

Date Signature of Delegate

Please enter the **Patient's** information below:

Patient's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Email Address:_____

Date of Birth: _____ Gender: Male ☐ Female ☐

I understand that the following items may be disclosed along with other health information in my health record: HIV/AIDS related information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drug/alcohol related diagnosis/treatment, referral information, genetic testing information and/or records, information about sexual assault/abuse, information about child abuse/neglect and domestic abuse of an adult with a disability. I understand that I may contact Newman Regional Health at any time to revoke this consent and restrict delegate access to my patient portal account and personal health information.

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Witness