Health Ministries Clinic
COMMUNITY HEALTH CENTER

PROXY ACCESS REQUEST AND AUTHORIZATION FORM

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: __/__/__
Last Name First Name Middle Initial MM/DD/YYYY

Address: _____
Number Street City State Zip Code

_____
Email Address

PROXY INFORMATION:

Proxy is an authorized individual granted access to the Patient Portal included but not limited to a parent or legal guardian, family caregiver, home health aide or a healthcare power of attorney.

Proxy Name: _____ Date of Birth: __/__/__
Last Name First Name Middle Initial MM/DD/YYYY

_____ _____
Phone Number Email Address

PLEASE CHECK ONE OF THE BOXES BELOW THAT BEST DESCRIBES THE PROXY ACCESS REQUEST

(Please note that for all types of proxy access, the patient's chart will be accessed through the proxy's Patient Portal account.)

ADULT PATIENT: ☐ **COMPLETE ACCESS**

Access to another adult's Patient Portal health record. (This also applies to Emancipated Minors. Minors must provide proof of emancipation.)

- ☐ **CAPABLE ADULT PATIENT:** Patient should sign this form to provide authorization for release of their medical information. Authorization for proxy access is valid until revoked by patient.
- ☐ **LEGAL GUARDIAN OF ADULT PATIENT:** Adults who have a surrogate relationship with another adult through a legal arrangement.

SELECT THE OPTION BELOW THAT BEST DESCRIBES THE GUARDIANSHIP:

- ☐ Legal Guardian (court order)
- ☐ Power of Attorney for Health Care
- ☐ Other: _____

- If you are the legal guardian or have a durable power of attorney for healthcare for this patient, then this request must be accompanied by a copy of the legal paperwork verifying our authority to have access to the patient's medical information.
- You must notify Health Ministries Clinic immediately in case of any change in authority.

ADOLESCENT-MINOR PATIENT: ☐ **COMPLETE ACCESS** ☐ **LIMITED**

Access to minor child's Patient Portal health record. Individuals requesting access must have parental rights / legal guardianship rights.

MY RELATIONSHIP TO THE CHILD IS:

- ☐ Parent
- ☐ Legal Guardian
  - Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient

Select one:

- ☐ **Child Aged 14-17 Patient:** Access to your teenage child's Patient Portal Record.
  - Health Ministries Clinic requires patients ages 14-17 to specifically indicate whether they permit their parent(s) or guardian(s) to have access to the portions of the patient's medical information specially protected under state laws, this includes reproductive, STD, mental health, and substance abuse information, by signing a separate agreement form.
  - When the patient becomes 18 years old, parent access will be turned off.

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Authorization:

- By signing this proxy request, I understand that I am giving my permission for Health Ministries Clinic, Inc. 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 including provider notes. By giving my proxy **Complete Access** I understand my proxy will have full access to my patient portal. By giving my proxy **Limited Access** I understand that my proxy will only have access to; my doctor, dental summary, growth chart, inbox and clinic hours.
- 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, (4) mental or behavioral health or psychiatric care, (5) pregnancy testing or (6) birth control.
- 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 Kansas State privacy laws.

By signing below, proxy acknowledges and agrees that:

- I will be using my own portal account at Health Ministries Clinic to access the above patient's portal account (i.e. Patient Portal or Healow app).
- For minors:
  - I have parental rights or legal guardianship rights to access this child's record.
  - I have not been denied periods of physical placement by the court system for this child.
  - Communication must be sent from the child's record and responses will be received in the child's record. Portal alerts will be sent to the e-mail address entered under the Parent/Legal Guardian ("Proxy") Information.

Legal Guardians:
Any documents, if any, I have provided in support of my right 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 Health Ministries Clinic in writing of the change in authority and mail it to the Health Information Management Department.

☐ **By checking this box, I acknowledge that I cannot access the patient portal and that I reject the use of proxy access.**

Patient: By signing below, I acknowledge and agree that:

- This proxy request is effective until my Patient Portal account is inactivated, or proxy access is revoked or expires on this specific date: _____
- I will comply with the terms and conditions stated in this document.

X_____ _____
Patient Signature (Required) Date (Required)

Proxy: By signing below, I acknowledge and agree that:

- I will be using my own "Patient Portal" account to access the patient's "Patient Portal" account.
- I will comply with the terms and conditions stated in this document.
- The patient can revoke my access to his/her Patient Portal account at any time.

X_____ _____ _____
Proxy Signature (Required) Relationship to Patient (Required) Date (Required)