Instructions for Completing the Patient Portal Proxy Authorization Form

Overview of the Proxy Form

Generally speaking, the parent is the personal representative of a minor. As a personal representative, the parent exercises the minor's HIPAA rights such as access to records, authorizations for disclosures, etc. Exceptions to this general rule where the parent is not the personal representative of the minor include:

- when the minor is the one who consents to the health care service and consent of the parent is not required under state or applicable law
- when the minor obtains health care services at the direction of the court or another person authorized by law
- when the parent agrees that the minor and the health care provider may have a confidential relationship with respect to health care services

It is important to note that an exception will apply if state or applicable law requires or permits access, prohibits access, or is silent on access. This exception is limited to Personal Health Information for particular health services and parents retain rights with respect to other services as the personal representative.

Additional variations can pertain to Sexually Transmitted Diseases, HIV, Family Planning, Substance Abuse and others. More information can be found online at sources such as: U.S. Department of Health & Human Services, American Academy of Family Physicians, American Pediatric Association, and the Federal Register 82635: Vol. 65, No. 250, 2000.

How to Complete Proxy Form *(continued on back)*

ADULT or MINOR PATIENT INFO ACCOUNT #* *Health Center Staff Will Complete

Last Name: _____ **First** Name: _____ **Middle** Initial: ____

Date of Birth: ____/____/____ mm / dd / yyyy **Phone**: _____ ❑Home ❑Cell ❑Work ❑Other **Last 4 Digits of SSN***: _____ *Required for Authentication

Address 1: _____ Mailing Address _____ City _____ State _____ Zip Code

Complete using the Patient Information.

ACCESS by PROXY Information

(The person authorized to access the PATIENT's health care information with My Health Onsite)

Last Name: _____ **First** Name: _____ **Middle** Initial: ____

Date of Birth: ____/____/____ (mm / dd / yyyy) **Gender**: ❑ **M** ❑ **F** **Preferred Language**: _____

Address 1: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

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

Does your Proxy have an active Patient Portal account with My Health Onsite? ❑ No ❑ Yes _____

Has the Proxy been a patient at My Health Onsite in the past? ❑ No ❑ Yes *If yes, Account #**

*Health Center Staff Will Complete

The proxy (parent, capable adult, or legal guardian) completes this section using their own information.

Check box to indicate Guardianship or Capable Adult Patient which would typically be a spouse or adult dependent.

ADULT		MINOR	
Access to another adult's Patient Portal information. **NOTE:** This section also applies to ***Emancipated Minors*** (Copy of proof of Emancipation must be attached to this form)		**Access to a minor's Patient Portal information.** My relationship to the minor 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)	
❑ **Capable Adult Patient**	❑ **Guardian of Adult**	❑ **0–12 years old**	❑ **13–17 years old**
The **Patient must sign this form** to provide authorization for release of their medical information. • *Authorization for proxy access is valid until submission of the Adult or Minor Proxy Revocation form by the Patient.*	Mark category of Guardianship: ❑ **Legal Guardian;** court ordered ❑ **Power of Attorney** for ❑ Healthcare ❑ Other: _____ Copy of legal document verifying your authority/guardianship or supporting documentation from your Employer Sponsor must be provided along with this Authorization release. **You must notify My Health Onsite IMMEDIATELY in the event your authority/guardianship status changes for this Patient.**	You will be authorized to full access to your minor's health care information with My Health Onsite until the minor turns 13 years old. • *If you have also been a patient with My Health Onsite, your minor's record will be accessible through your Patient Portal access point.* • *When the Patient turns 13 years old they can choose whether parent/guardian can access to their Patient Portal. If continued access is desired by both Patient and Proxy, a new Proxy Authorization form can be completed.*	Patients of 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. • *When the Patient becomes 18 years old, parent/guardian access to their Patient Portal will be disconnected. If continued access is desired, a new Proxy Authorization form can be completed after they turn 18 years old.*

Check the box that reflects the relationship to the minor patient.

Check the box that reflects the age category of minor patient.

Check the box that reflects the access type: Complete access is not limited and restricted access limits portal functionality to services like appointment setting only.

understand that my use of the Patient Portal is voluntary and that I am not required to use it to access my medical record.

Please Check One: (Required) ❑ **COMPLETE ACCESS** ❑ **RESTRICTED ACCESS**

Adult or Minor Patient (13–17 years old)

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 _____

Adult or Minor Patient Signature *(Required)*

_____ (Relationship to Proxy *(Required)*) _____ (Date *(Required)*)

Proxy

By signing below, I acknowledge, agree & understand:

1. I will comply with the Patient Portal **Terms and Conditions**.
2. The patient can revoke my access to his/her Patient Portal account at any time unless the patient is a minor aged zero to 12.

X _____

Proxy Signature *(Required)*

_____ (Relationship to Adult or Minor Patient *(Required)*) _____ (Date *(Required)*)

Signature of adult patient giving access to another adult or minor patient between 13–17 years of age if applicable. *No signature if patient is 12 or younger.*

Signature of person receiving permission to use and access Patient's Portal.

MY HEALTH ONSITE℠

Patient Portal Proxy Authorization

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

ADULT or MINOR PATIENT INFO

ACCOUNT #* _____
*Health Center Staff Will Complete

Last Name: _____ **First** Name: _____ **Middle** Initial: ____

Date of Birth: ____/____/____ (mm / dd / yyyy) **Phone**: _____ ❑ Home ❑ Cell ❑ Work ❑ Other

Last 4 Digits of SSN*: _____
*Required for Authentication

Address 1: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

ACCESS by PROXY Information

(The person authorized to access the PATIENT's health care information with My Health Onsite)

Last Name: _____ **First** Name: _____ **Middle** Initial: ____

Date of Birth: ____/____/____ (mm / dd / yyyy) **Gender**: ❑ **M** ❑ **F** **Preferred Language**: _____

Address 1: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

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

Does your Proxy have an active Patient Portal account with My Health Onsite? ❑ No ❑ Yes _____

Has the Proxy been a patient at My Health Onsite in the past? ❑ No ❑ Yes *If yes, Account #**
*Health Center Staff Will Complete

ADULT

Access to another adult's Patient Portal information.

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

❑ Capable Adult Patient

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

- *Authorization for proxy access is valid until submission of the Adult or Minor Proxy Revocation form 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 or supporting documentation from your Employer Sponsor must be provided along with this Authorization release.

You must notify My Health Onsite IMMEDIATELY in the event your authority/guardianship status changes for this Patient.

MINOR

Access to a minor's Patient Portal information.

My relationship to the minor 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)

❑ 0–12 years old

You will be authorized to full access to your minor's health care information with My Health Onsite until the minor turns 13 years old.

- *If you have also been a patient with My Health Onsite, your minor's record will be accessible through your Patient Portal access point.*
- *When the Patient turns 13 years old they can choose whether parent/guardian can access to their Patient Portal. If continued access is desired by both Patient and Proxy, a new Proxy Authorization form can be completed.*

❑ 13–17 years old

Patients of 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.

- *When the Patient becomes 18 years old, parent/guardian access to their 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 care information at My Health Onsite.
(Does not apply to Legal Guardian, Power of attorney, or 0–12 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 MEDICAL RECORD/PATIENT PORTAL

1. By signing this proxy request, I understand that I am giving my permission for Medical Risk Solutions (MRS), dba My Health Onsite, 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 and radiology results, immunizations, billing and appointment information. Additionally, I understand that granting proxy access to a third party is completely voluntary and I hereby agree to waive any and all claims or causes of action against My Health Onsite, its affiliated entities, their officers, directors, employees, and agents that are in any way related to my proxy's use of my medical record.
2. I understand that I may choose to allow my proxy "Complete Access" or "Restricted Access" by checking the appropriate access election box below. Unless I check "Restricted Access," 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.
3. It is understood that the proxy's acitivities within my medical record in the Patient Portal may be tracked by computer audit and that any entries and messages may become part of my medical record.
4. I understand this consent will remain in effect until revoked by completing the My Health Onsite Adult or Minor Proxy Revocation form.
5. 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.
6. I understand that if my proxy shares his/her user ID and password with anyone, or if his or her user ID and password are lost or stolen, unauthorized parties may have access to my medical record information and is it the responsibility of my proxy to keep his/her user ID and password secure and to change them anytime they believe their security has been compromised.
7. I understand that it is my responsibility to terminate my proxy's access to my medical record through the Patient Portal if I no longer wish to allow him/her access to my medical record information in the Patient Portal. Termination of proxy access is not immediate. My Health Onsite will use its best efforts to terminate your proxy's access to your medical record information in the Patient Portal within ten (10) business days of receiving the My Health Onsite Adult or Minor Proxy Revocation form.
8. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Florida state privacy laws.
9. I understand that access to my medical record through the Patient Portal is provided as a convenience to patients and that My Health Onsite has the right to deactivate my access or my proxy's access to the Patient Portal at any time for any reason or for no reason. Additionally, I understand that my use of the Patient Portal is voluntary and that I am not required to use it to access my medical record.

Please Check One: (Required) ☐ **COMPLETE ACCESS** ☐ **RESTRICTED ACCESS**

Adult or Minor Patient (13–17 years old)

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 _____

Adult or Minor Patient Signature *(Required)*

_____ _____

Relationship to Proxy *(Required)* Date *(Required)*

By signing below, parent or legal guardian acknowledge and agrees:

- I have parental rights or legal guardianship rights to access the Minor's Patient Portal account.
- I have not been denied periods of physical placement with the Minor and there are no court orders or restraining orders in effect limiting my access to this Minor's medical records and/or information.
- Communications on behalf of the Minor through the Patient Portal must be sent from the Minor's record and responses will be received in the Minor's record. Patient Portal e-mail alerts will be sent to the e-mail address entered under the Parent/Legal Guardian ("Proxy") Information.
- For a Minor age zero to 12 years, I will be granted full access to the Minor's Patient Portal record. On the Minor's 13th birthday, a new Patient Portal Proxy Authorization form must be completed.

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 My Health Onsite in writing of the change in authority & the date it became effective, and mail it to ***My Health Onsite, ATTN: Patient Services, 2710 Rew Circle, Suite 200, Ocoee, FL 34761***

Proxy

By signing below, I acknowledge, agree & understand:

1. I will comply with the Patient Portal **Terms and Conditions**.
2. The patient can revoke my access to his/her Patient Portal account at any time unless the patient is a minor aged zero to 12.

X _____

Proxy Signature *(Required)*

_____ _____

Relationship to Adult or Minor Patient *(Required)* Date *(Required)*