



PATIENT PORTAL PROXY ACCESS REQUEST AND AUTHORIZATION FORM

Designating a Proxy. Proxy access gives someone that you name the ability to view your medical record information via the MyAugusta Health Portal. You may cancel your Proxy's access at any time by sending written notification with a signature to the Health Information Management (HIM) Department at Augusta Health, or by completing the Proxy Revocation form found in the Forms section of the Patient Portal home page. Completed form can be returned to HIM by mail at Augusta Health, Attn: HIM, 78 Medical Center Drive, Fishersville, VA 22939, by email at medicalrecords@augustahealth.com, or by fax at (540) 332-4058.

PATIENT INFORMATION

PATIENT NAME: LAST, FIRST, MIDDLE INITIAL		SEX:	DATE OF BIRTH	LAST 4 NUMBERS OF SSN:
STREET ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:	MOBILE PHONE:		WORK PHONE:	
EMAIL ADDRESS:				

PROXY INFORMATION

*****Please complete the box below that best describes the proxy access requested*****

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

Access to another adult's MyAugusta Health Portal record.

(Note: This section also applies to Emancipated Minors. Emancipated Minors must provide proof of emancipation.)

Relationship of Proxy to Adult Patient is:

☐ **Other Adult**

- The patient must sign this form to provide authorization for release of their medical information to any of the above proxies via the MyAugusta Health Portal.
- Authorization for proxy access is valid until revoked by patient.

☐ **Legal Representative of Adult Patient:** (Adults who have a surrogate relationship with another adult through a legal arrangement). **Select the option below that best describes this Representative relationship:**

- ☐ Power of Attorney for Health Care (with current authority)
- ☐ Legal Guardian (court order)
 - If you are the legal guardian or you have current authority under a durable power of attorney for healthcare for this patient, then this request must be accompanied by a copy of the legal paperwork verifying your authority to have access to the patient's medical information.
 - You must notify Augusta Health immediately in case of any change in authority.

☐ Other (specify) _____

MINOR PATIENT

Access to your minor child's MyAugusta Health Portal record.

- Individuals requesting access must have parental rights or legal guardianship right.

My relationship to the Child is:

- ☐ Parent – Is there a court order in effect limiting your access to the minor's medical records and information? ☐ Yes ☐ No
- ☐ Permanent Legal Guardian of the Minor – You 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 (age 0-12 Patient):** You will be granted access to your child's record until the child turns 13 years old.

**** At 13 years of age, the patient can have their own portal account. The parent/guardian can call in to set the account up for the patient, and then access can be granted via Shared Access.**

☐ **Child (age 13-17 Patient):** When Shared Access is not feasible. You will be granted access to your child's records until the child turns 18 years old.

Please Note – Proxy access to your 0-17 year-old minor's Patient Portal may take 3-5 days.

Does the proxy have an active MyAugusta Health Portal? ☐ Yes ☐ No

Has the proxy ever been a patient at Augusta Health? ☐ Yes ☐ No

Provide proxy information below:



Medical Record #: _____ (completed by Augusta Health)

PROXY NAME: LAST, FIRST, MIDDLE INITIAL		SEX:	DATE OF BIRTH	LAST 4 NUMBERS OF SSN:
STREET ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:	MOBILE PHONE:		RELATIONSHIP TO PATIENT:	
EMAIL ADDRESS:				

PATIENT AUTHORIZATION

PATIENT:

I understand and agree that:

- I am authorizing Augusta Health and its affiliates and contractors to disclose all information on the MyAugusta Health Portal to the proxy named above, at the request of the proxy from time to time. Authorization for these disclosures will expire upon Augusta Health's receipt of a completed form for termination of proxy access, as described below.
- Subject to Augusta Health policies and procedures and the Terms and Conditions, for adult patients, the proxy's access will remain in effect unless and until Augusta Health receives a completed form for termination of Proxy access.
- I understand that I am responsible for ensuring that the information set forth above, including, without limitation, the email address and other information, is accurate and complete.
- I choose to designate the person named above as a proxy to MyAugusta Health Portal, thereby allowing him/her access to my protected health information. I authorize release of any information contained in MyAugusta Health Portal to my designated proxy. I understand that the medical information in MyAugusta Health Portal is obtained from my electronic medical record but is not my complete medical record.
- Participation in MyAugusta Health Portal and designating a proxy is completely voluntary. I understand that I am not required to designate a MyAugusta Health Portal proxy, and I am not required to provide this authorization. I also understand that Augusta Health does not condition any of my health care treatment, payment, or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, Augusta Health may decline to provide access to my MyAugusta Health Portal to my designated proxy.
- I understand that if I no longer want the proxy to have access to MyAugusta Health Portal, I may request that Augusta Health revoke his/her access by submitting a completed Proxy Revocation form by mail to Augusta Health, Attn: HIM, 78 Medical Center Drive, Fishersville, VA 22939, by email to medicalrecords@augustahealth.com, or by fax at (540) 332-4058.



Signature of Patient* (Wet Signature Required)

Date/Time

If this document is executed by the proxy identified above or another representative on behalf of the patient identified above, the undersigned agrees:

- The MyAugusta Health Portal contains medical information but is not the complete patient medical record.
- Subject to Augusta Health's policies and procedures, in most cases, the patient can revoke the proxy's access to his/her MyAugusta Health Portal at any time.
- If I am signing this document on behalf of the patient, I represent and warrant that I am fully authorized to execute this document on behalf of the patient and to access and grant access to information about the patient on the MyAugusta Health Portal, and I agree that I will notify Augusta Health in writing immediately if my relationship or the relationship of the proxy with the patient changes (for example, if I am no longer the guardian of the patient).



Signature of Patient Representative* (Physical Signature Required)

Date/Time

***The Patient Representative is the patient's decision maker with current authority. It can be the parent if the patient is a minor, a legal guardian, health care power of attorney, or other person with current legal and representative authority.**

Completed form to be sent to HIM (Medical Records) Department. Completed form will be scanned to patient's Medical Record.

Questions? Call: 540-332-4657