❑ Ob/Gyn Biltmore ❑ FHC Biltmore ❑ FHC Cane Creek ❑ FHC Newbridge
❑ FHC Enka/Candler ❑ FHC Lake Lure ❑ Swannanoa ❑ Deerfield ❑ Givens

FOR OFFICE USE ONLY: **PROXY**

Front office review by: _____on_____
MR# _____
MR review by _____ on _____
Invite sent by _____on _____

FollowMyHealth Patient Portal Proxy Access

Patient Portal Proxy Access Request and Authorization Form for Mountain Area Health Education Center, Inc. (MAHEC)

ALL INFORMATION IN THIS BOX IS REQUIRED TO PROCESS YOUR PROXY AUTHORIZATION

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Last First M.I.
Address: _____ Last 4 digits of SS #: _____
Street Address City, State Zip Code *(This will be your access code)*

PROXY INFORMATION: (person to whom you authorize MAHEC to release the Patient Portal record)

Proxy Name: _____ Date of Birth: _____
Last First M.I.
Address: _____ Phone Number: _____
Street Address City, State Zip Code

Email address: _____

Please check one of the boxes 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 FollowMyHealth Patient Portal account.)

ADULT PATIENT

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

Select one:

☐ **Adult for Capable Adult Patient:**
- The patient should sign this form to provide authorization for release of his/her 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 you have a power of attorney for healthcare for this patient, this request must be accompanied by a copy of the legal paper work verifying your authority to have access to the patient's medical information.
- You must notify MAHEC immediately in case of any change in authority.

MINOR PATIENT

Access to your minor child's Patient Portal record.

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

My Relationship to the Child is:

☐ Parent

☐ Permanent Legal Guardian of the Patient *(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:

☐ **Adult for Child Patient Age 0-10:** Subject to North Carolina law, you will be granted full access to your child's record until the child turns 11 years old.

Patient Authorization:

- By signing this proxy request, I understand that I am giving my permission for MAHEC to disclose my protected health information (PHI) through the Patient Portal to my proxy which may include sensitive information such as treatment for pregnancy, drug/alcohol abuse, mental health, HIV status, genetic testing and labs, if applicable.
- This proxy request is effective until my Patient Portal account is inactivated or I revoke proxy access.
- 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 North Carolina 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 my Patient Portal account will not be granted.

By signing below, proxy acknowledges and agrees that:

- I will be using my own FollowMyHealth Patient Portal account to access the patient's Patient Portal account.
- As indicated, I have parental rights or legal guardianship rights to access this patient's record.
- I have not been denied periods of physical placement with the patient and there are no court orders or restraining orders in effect limiting my access to this patient's medical records and/or information.
- Communications on behalf of the patient through the Patient Portal must be sent from the patient's record and responses will be received in the patient's record. Patient Portal e-mail alerts will be sent to the e-mail address entered under "Proxy Information."
- For a child age 0-10 years, I will be granted full access to the Child's medical record, subject to NC law.

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 expires, I must immediately notify MAHEC in writing of the change in authority and mail it to the Health Information Management Department.

Patient Signature: By signing below, I acknowledge and agree that I will comply with the terms and conditions contained in this document and understand that I can revoke this proxy access at any time by notifying MAHEC in writing (only sign on one applicable line).

I am an **Adult Patient/Emancipated Minor** Authorizing Proxy Access to my account:

X _____ _____

Patient Signature (Required) Date (Required)

I am the **Parent/Legal Guardian** of the Patient Authorizing Proxy Access to his/her account:

X _____ _____ _____

Parent or Legal Guardian Signature (Required) Relationship to Patient (Required) Date (Required)

Proxy Signature: By signing below, I acknowledge and agree that I will be using my own FollowMyHealth Patient Portal account to access the patient's Patient Portal account. I will comply with the terms and conditions contained in this document and understand the patient can revoke my access to his/her Patient Portal account at any time.

I am the **Individual/Proxy** receiving access to the Patient's account:

X _____ _____ _____

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