MyChart Guardian/Conservator/POA of Adult Proxy Request and Authorization Form

BalladHealth

Patient Identification

This form should be completed by a legal guardian, conservator, or acting durable Power of Attorney for Healthcare ("Requestor") to select an individual who may obtain access ("Proxy") to portions of the electronic protected health information ("ePHI") maintained by Ballad Health and/or its affiliated entities (the "Organization") through MyChart for an adult who lacks decision-making capacity and for whom the requestor is acting as the legal guardian/conservator/POA. The Proxy will need to show his/her photo ID and the information specified below.

Guardian/Conservator/POA for Adult Proxy:

If patient does not have the ability to make and understand his/her own health care decisions, a patient's guardian/conservator/POA can follow these steps:

1. Requestor completes the "Guardian/Conservator/POA for Adult Proxy Request Form"; and
2. If Requestor is:
    a. Permanent Legal Guardian for Patient: Guardian brings a.) Court Order Appointing Guardian; and b.) any letters of guardianship verifying the status as permanent legal guardian of the patient;
    b. Conservator for Patient: Conservator brings a.) Court Order Appointing Conservator; and b.) any documentation verifying the status as conservator of the patient;
    c. Activated durable Power of Attorney for Healthcare (POA): POA brings: a.) valid Durable Power of Attorney for Healthcare; and b.) two Physician Certifications verifying the patient lacks decision-making capacity; and
3. Requestor takes completed forms to clinic with his/her photo ID. Requestor submits forms to front desk person at clinic or health care provider and shows photo ID; and
4. If Proxy sees providers at our organization, Proxy must ask front desk person to sign up for MyChart.
5. Patient's MyChart account will be attached to Proxy's MyChart account when entire process is completed.

NOTE: Requestor must agree to notify Ballad Health if his/her guardianship/conservatorship/POA becomes invalid for any reason and Proxy must agree to cease all access to patient's record as of the time such guardianship is invalidated.

Adult Patient Information:

Patient Information: Please fill in the information requests in bold below:

Patient's Name: _____ **Date of Birth:** _____

Address: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____ **Alternate Telephone Number:** _____

Last 4 digits of Social Security Number: _____

Medical Record Number: _____

Requestor Information:

Name: _____ **Date of Birth:** _____

Address: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____ **Alternate Telephone Number:** _____

Last 4 digits of Social Security Number: _____

Medical Record Number: _____

Email address: _____

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My Relationship to the Patient is as follows:

- ❒ **Permanent Legal Guardian of the Patient** – Must attach a copy of the documentation listed on Page 1.
- ❒ **Conservator of Patient** – Must attach a copy of the documentation listed on Page 1.

OR

- ❒ **Activated Durable Power of Attorney for Healthcare (POA)** – Must attach a copy of the documentation listed on Page 1.

As the Requestor in my capacity as Guardian/Conservator/POA, I wish to designate the following person as a Proxy to access ePHI of the Patient:

_____ _____

Name Requestor Signature

<u>Proxy Information</u> (if Proxy is an individual user other than the Requestor):
If the Proxy sees providers at the organization, the Proxy needs to also complete the Enrollment Form if not already completed.

Proxy Name: _____ **Date of Birth:** _____

Address: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____ **Alternate Telephone Number:** _____

Last 4 digits of Social Security Number: _____

Medical Record Number: _____

Email address: _____

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

- I will be using my own MyChart account at the Organization to access the Patient's MyChart account.
- I will comply with the MyChart terms and conditions and the conditions set forth in this document.
- I will keep my password confidential and not share this information with anyone.
- Communications on behalf of the patient through MyChart must be sent from the patient's record and responses will be received in the patient's record. MyChart e-mail alerts will be sent to the e-mail address entered under the Legal Guardian//Conservator/POA/Proxy information sections.
- I have completed all paperwork requirements for proxy access as set forth in the "MyChart Proxy Access Paperwork Requirements" policy.

x_____/_____/_____

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

For Official Use:

1. I have given a photocopy of the signed MyChart Authorization documents to the Patient.
2. I HAVE PLACED A PATIENT LABEL ON EACH OF THE PAGES GOING TO MEDICAL RECORDS.
3. I have viewed the Patient's photo ID on _____ by: _____

*Date:*_____ *Signature of:* _____

