Dependant Adult Proxy Consent

Notice: This is a HIPAA Agreement Form

Thank you for expressing interest in the FollowMyHealth® patient portal. The Hutchinson Clinic looks forward to your participation!

To request proxy access to view an adult's health information using FollowMyHealth®, the Durable Power of Attorney or legal guardian must complete the "Dependant Adult Proxy Consent." After all information is verified, you will receive an email invitation from noreply@followmyhealth.com. Within this email you will also find your invitation code that has been assigned to you.

HIPAA: The federal **Health Insurance Portability and Accountability ACT** (HIPAA) of 1996, along with state law, mandates the privacy and security of Protected Health Information (PHI); the portability of health insurance and simplification of electronic billing.

- The information you are requesting access is Protected Health Information (PHI). Having proxy access allows you to view the dependant patient's entire PHI. The Hutchinson Clinic will not be responsible for a HIPAA breach determined to be intentional by proxy access or occurred outside of the Hutchinson Clinic.

By completing and signing this form:

1. I certify that I am the Power of Attorney/legal guardian of the patient and I have the legal right to access his or her health information.
2. I understand that any individuals I name below will have online access to personal health information, including, but not limited to, viewing portions of the health record, requesting appointments, and requisition medication refills.
3. I understand that additional information may be made available to me through the patient portal in the future.
4. I understand that this form only gives access to the patient's health record. This form does not authorize the release of the patient's medical record by other methods or in other formats. To request copies of the patient's medical record, please contact our Health Information Department.
5. I understand this consent must be signed by a representative of the Hutchinson Clinic or my request for access will be denied.
6. I understand that access to the patient's portal is provided by Hutchinson Clinic as a convenience to its patients. Hutchinson Clinic has the right to deactivate access to the PHR at any time, for any reason.

PATIENT'S INFORMATION

Name: ____________________________________ **Patient #:** __________________________

DOB: ________________ **Phone:** _____________________________

Street Address: _________________________________ **City, State, and Zip Code:** _________________________

DURABLE POWER OF ATTORNEY/GUARDIAN INFORMATION

Name: ____________________________________ **Phone:** _____________________________

Street Address: _________________________________ **City, State, and Zip Code:** _________________________

DOB: ________________ **Email Address:** _____________________

Relationship to Patient: ___ **Durable Power of Attorney*** ___ **Legal Guardian****

Durable Power of Attorney/Legal Guardian Signature: ____

*DPOA's **MUST** provide a copy of an **effective** Healthcare Durable Power of Attorney that states said person has the right to this information. Failure to submit this will result in denial of access.

*Legal Guardian's **MUST** provide a copy of legal paperwork that such person has the right to this information. Failure to submit legal paperwork will result in denial of access.

ADDITIONAL DURABLE POWER OF ATTORNEY/GUARDIAN ACCOUNT(S)

By completing this section, I am requesting the Hutchinson Clinic to give access to the following individual(s):

Name: ____________________________________ **Phone:** _____________________________

Street Address: _________________________________ **City, State, and Zip Code:** _________________________

DOB: ________________ **Email Address:** _____________________

Relationship to Patient: ___ **Durable Power of Attorney*** ___ **Legal Guardian**** ____________ **Other (Specify)**

Access Level: ___ **Full Access** ___**Read Only Access**

For office use only:

ID Verified by (print name): ______________________________ **Witnessed signature (required):** _________________________

Verified Legal Documentation on file: YES or NO **Date Invitation sent:** ____