MyVHC Proxy Access Request and Authorization Form

1. Patient Information: (All sections required – please print clearly)

Name (*last, first, middle initial*): _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address (if applicable): _____

Date of Birth: _____ MRN: _____ Phone Number: (_____) _____ - _____

2. Proxy Information: (All sections required – please print clearly)

Name (*last, first, middle initial*): _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Date of Birth: _____ Phone Number: (_____) _____ - _____

Has the proxy ever been a patient at Virginia Hospital Center Arlington Health System? ☐ Yes ☐ No

3. 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 MyVHC Patient Portal account.)

Adult Patient

Access to another adult's Patient Portal record.

Select One:

☐ **Adult-Adult Patient:**
- The patient should sign this form to provide authorization for release of their medical information.
- The patient is ***competent/capable*** of understanding and making his/her health care decisions.
- Authorization for proxy access is valid until revoked by patient.

☐ **Legal Guardian of Adult Patient:** [Adult who has Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian to the adult patient.]
- This request must be accompanied by a copy of the legal paper work verifying the Proxy's authority to have access to the patient's medical information.
- You must notify VHCAHS immediately in case of any change in authority.

☐ **Power of Attorney for Adult Patient:** [Adult who has Activated Durable Medical Power of Attorney for Healthcare (DPOA) or Healthcare Proxy (Advanced Directive) for the adult patient]
- This request must be accompanied by a copy of the legal paper work verifying the Proxy's authority to have access to the patient's medical information.
- You must notify VHCAHS 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 (Age 0-17 Patient) is:

☐ **Parent:**
- Must provide Photo ID

☐ **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.

☐ **Power of Attorney for Patient:**
- Must attach a copy of the Activated Medical Power of Attorney (MPOA) verifying the Proxy's status as Power of Attorney to make medical decisions for the patient.

CO0009

VIRGINIA HOSPITAL CENTER

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663024-05102018

Patient Label

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Authorization:

- By signing this proxy request, I understand that I am giving permission for Virginia Hospital Center Arlington Health System to disclose my protected health information (PHI) through the MyVHC Patient Portal to my Proxy. Information available through MyVHC Patient Portal includes, but is not limited to: health summary, current problem list, current medications, lab results, and appointment information.
- I understand that 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 substance use, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request is effective until my MyVHC Patient Portal account is inactivated, proxy access is revoked or, if filled in, will expire on this specific date: _____.
- 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 privacy laws of the Commonwealth of Virginia.
- 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 MyVHC Patient Portal account for my Proxy will not be granted.

By signing below, parents or a legal guardian of a minor acknowledge and agree that:

- I will be using my own MyVHC Patient Portal account at Virginia Hospital Center Arlington Health System to access the Child's Patient Portal account.
- I have parental rights or legal guardianship rights to access this Child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- Communication on behalf of the Child through MyVHC Patient Portal must be sent from the Child's record and responses will be received in the Child's record. MyVHC Patient Portal e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") Information.
- For a child age 0-17 years, I will be granted full access to the Child's MyVHC Patient Portal record. On the Child's 18th birthday, I will no longer have access to the Child's MyVHC Patient Portal record.

Legal Guardians/Power of Attorney for Patient:

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 expired, I will immediately notify Virginia Hospital Center Arlington Health System in writing of the change in authority and mail it to the Health Information Management Department.

Patient/Parent or Legal Guardian of Minor Patient: By signing below, I acknowledge and agree that:

- I will comply with the terms and conditions on the MyVHC Patient Portal Terms and Conditions page and this document.

X_____ _____ _____

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

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

- I will be using my own MyVHC Patient Portal account to access the patient's MyVHC Patient Portal account.
- I will comply with the terms and conditions on the MyVHC Patient Portal Terms and Conditions.
- The patient can revoke my access to his/her MyVHC Patient Portal account at any time.

X_____ _____ _____

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

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