Patient Name: _____
FC: _____ MRN: _____
Sex: ____ DOB: _____ Age: _____
Adm Date: _____ ACCT: _____

MyARHChart Portal Proxy Request

Patient Information:

Patient Name: _____ Date of Birth: _____
Last Name First Name M.I.

Address: _____
Street Address City, State Zip Code

Proxy Information: (Person to whom you authorize ARH to give access to your *MyARHChart* record)

Proxy Name: _____ Date of Birth: _____
Last Name First Name M.I.

Relationship to Patient: _____

Email address: _____
Does the proxy have a Patient Portal account? ❑ Yes ❑ No (Proxy must have a *MyARHChart* account)

Type of Proxy Access Requested:

(For all types of proxy access, the patient's chart will be accessed through the proxy's *MyARHChart* account)

Adult Patient

(Access to another adult's *MyARHChart* or Access to Emancipated Minors *MyARHChart - Patient must sign*)

Choose One:

❑ **Adult-capable Adult Patient:** Patient should sign this form to provide authorization for release of their medical information. Authorization for proxy access is valid until revoked by patient.

❑ **Legal Guardian of Adult Patient:** If guardianship, choose type.
- ❑ Legal Guardian (court order)
- ❑ Power of Attorney for Health Care
- ❑ Other: _____

• *You must notify ARH immediately in case of any change in authority.*

Adolescent Patient

(Access to your child's (12 years and over) MyARHChart account - BOTH Patient and Proxy must sign)

• *KRS 214.185 allows minors, in certain situations, to be treated without parental/guardian consent. Under HIPAA 45 CFR 164.502, this sometimes prevents ARH from releasing information to the parent/guardian without child's acknowledgement.*

My Relationship to the Adolescent Child is:
- ❑ **Parent**
- ❑ **Permanent Legal Guardian of the Patient**

Minor Patient*

(Access to your minor child's (0-11 years of age) MyARHChart account - Proxy must sign)

My Relationship to the Child is:
- ❑ **Parent**
- ❑ **Permanent Legal Guardian of the Patient**

IMPORTANT INFORMATION:
When the child reaches 12 years of age all proxy access will be removed.

SEND COMPLETED REQUEST FORM TO H.I.M. FOR PROCESSING

Pt Name:_____ Sex: _____ DOB:_____ Age:_____ FC: _____ MRN: _____ Date of Service:_____

MyARHChart Portal Proxy Request

Patient Authorization:

- By signing this proxy request, I understand that I am giving my permission for Appalachian Regional Healthcare, Inc. (ARH) to disclose my protected health information (PHI) to my proxy through the *MyARHChart* patient portal application. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, and appointment information.
- 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 drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request is effective until *MyARHChart* patient portal account is inactivated or proxy access is revoked.
- 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.

By signing below, parents acknowledge and agree that:

- I will be using my own *MyARHChart* patient portal account at ARH to access the Child's PHI.
- 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.
- Communications on behalf of the Child through *MyARHChart* patient portal must be sent from the Child's record and responses will be received in the Child's record. *MyARHChart* patient portal e-mail communications will be sent to the e-mail address on file at ARH for the Parent/Legal Guardian ("Proxy").

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 expired, I must immediately notify ARH in writing of the change in authority.

Patient: By signing below, I acknowledge and agree with the above.

_____ _____

Patient, Parent or Legal Guardian Signature Date / Time Relationship to Patient

Parent/Legal Guardian: By signing below, I acknowledge and agree with the above.

_____ _____

Parent/Legal Guardian Signature Date / Time Relationship to Patient

SEND COMPLETED REQUEST FORM TO H.I.M. FOR PROCESSING