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)

Adult Proxy Access Requested For:

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

- ❑ Legal Guardian (court order)
- ❑ Power of Attorney for Health Care
- ❑ Other: _____

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.

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 or Legal Guardian Signature Date / Time