INSTRUCTIONS FOR COMPLETING PATIENT PORTAL PROXY ACCESS AUTHORIZATION FORM

This form will authorize giving an individual (proxy) access to medical information contained in another person's (patient) Patient Portal ("Portal").

Section 1 fill in the name, birth date, address, phone number, and email of the patient whose Portal will be accessible by the proxy ("Patient").

Section 2 fill in the name, birth date, address, phone number, and email of the individual ("Proxy") who will access medical information that is available in the Portal.

Section 3 specify the relationship between the Proxy and the Patient. There must be no court orders or restraining orders in effect prohibiting the Proxy's right to have access to the Patient's medical records. **The person completing this form must fall within one of the following categories for access to be granted to the Portal:**

- Adult Patient who has the authority to grant others access to their medical information; or
- Patient advocate of an adult Patient under an activated Durable Power of Attorney for Health Care; or*
- Court-appointed guardian of an adult Patient; or*
- Court-appointed guardian of a minor Patient; or*
- Parent (non-foster parent) with legal rights to make important decisions on behalf of a minor (under 13 years old) Patient; or
- Foster parent of a minor (under 13 years old) Patient.*

**These relationship statuses require that the individual signing the form provide legally valid paperwork confirming the individual's authority to access the Patient's medical information.*

Section 4 read the terms and conditions of granting the Proxy access.

PLEASE NOTE: By signing this form, you understand and agree that:

1. **The information available in the Portal may include, but is not limited to, the diagnosis and/or treatment of mental illness, substance use disorder treatment and medication assisted treatment, sexually transmitted infections (including HIV or AIDS test results), developmental disabilities and genetic testing results.**
2. The Proxy is not covered under the Health Insurance Portability and Accountability Act of 1996 and may not be subject to federal or state privacy laws. Information disclosed to the Proxy may no longer be protected by federal or state law.
3. When the Proxy's authority to access the Patient's medical records has been inactivated, revoked, terminated, or expired, the Proxy will no longer access the Patient's Portal and will immediately notify Munson Healthcare in writing of the change in authority by mail, fax or email
4. **If the individual signing the form is the Minor Patient, the information available in the Portal may include medical records for treatment the Minor Patient consented to on their own, including, but not limited to outpatient mental health care, prenatal and pregnancy-related care, substance use disorder treatment, and sexually transmitted infections (including HIV or AIDS test results).**
5. If the individual signing the form is the **Parent (non-Foster)** or **Foster Parent of a Minor Patient:**
   a. Communications on behalf of the Minor through the Portal must be sent from the Minor's Portal and responses will be received in the Minor's Portal.
   b. For a Minor age 0 to 12 years, the Proxy will be granted full access to the Minor's Portal record. On the Minor's 13th birthday, the Proxy's access will be turned off.
   c. The Proxy will be using their own Portal account to access the Minor's Portal account.
   d. The individual signing the form has the legal right to access the Minor's medical records.
   e. There are no court orders or restraining orders in effect prohibiting the Proxy's access to the Minor's medical records.
6. If the individual signing the form is the **Patient Advocate** or **Court-Appointed Guardian**, documents provided in support of the Proxy's right to access the Patient's medical records are true and correct and are the most recent documents.

PLEASE SUBMIT THIS FORM BY MAIL, FAX OR EMAIL TO:

MUNSON MEDICAL CENTER
1105 6th Street
Traverse City, MI 49684

Fax: 231-392-7304
Email: patientportals@mhc.net

***OR* DROP OFF IN PERSON TO ANY MHC FACILITY OR PHYSICIAN OFFICE**

MUNSON HEALTHCARE

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PATIENT PORTAL PROXY AUTHORIZATION

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1. Patient Information:

Patient Name: _____ Date of Birth: _____
Last First Middle initial

Address: _____
Street Address City State Zip Code

Phone Number: _____ Email Address: _____

2. Proxy's Information:

Proxy Name: _____ Date of Birth: _____
Last First Middle initial

Address: _____
Street Address City State Zip Code

Phone Number: _____ Email Address: _____

3. Relationship of Individual Requesting Proxy Access to the Patient's Portal:

- ☐ I am the ADULT patient who has the authority to grant others access to my medical information
- ☐ I am the Patient Advocate of the ADULT patient under an activated Durable Power of Attorney for Health Care*
- ☐ I am the Court-Appointed Guardian of the ADULT patient*
- ☐ I am the Court-Appointed Guardian of the MINOR patient*
- ☐ I am the Parent (non-Foster) with legal rights to make decisions on behalf of the MINOR (under 13 years old patient
- ☐ I am the Foster Parent of the MINOR (under 13 years old) patient*

*Requires legally valid paperwork confirming authority to access the patient's medical information

4. Terms and Conditions of Proxy Authorization: By signing this form, I (the patient or Patient's legal representative):

A. I authorize Munson Healthcare and its affiliates to disclose any of the Patient's medical information which is available in the Portal to the Proxy. **I understand that this includes medical information created by providers within Munson Healthcare related to substance use disorder treatment and medication assisted treatment.**

B. I understand that I may refuse to sign this form and that my refusal to sign will not affect the Patient's ability to obtain treatment If I refuse to sign, access to the Patient's Portal by the Proxy will not be granted.

C. I understand that I can revoke (cancel) the Proxy's access to the Patient's Portal at any time by providing written notice to Munson Healthcare. Revoking the Proxy's access will not have any effect on any actions taken in reliance on the authorization granted in this form or on any medical information already released to the Proxy.

BY SIGNING BELOW THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE ACKNOWLEDGES AND AGREES: If there is medical information that should not be shared with the Proxy, I should not sign this form.

_____ _____ _____
Patient, Parent or Legal Representative Signature **Name** **Date**

BY SIGNING BELOW, THE PROXY ACKNOWLEDGES AND AGREES: The Proxy will not re-disclose any information accessed through the Patient's Portal if such re-disclosure is prohibited by federal or state law.

_____ _____
Proxy Signature **Date**

Completed by: _____ Staff Location: _____
Staff Signature Date