ST. JOSEPH'S HEALTH Hospital
A Member of Trinity Health

Slocum-Dickson Medical Group P.L.L.C.

SJH126

Adult Proxy Form

Access to another Patient's My St. Joseph's Record

To request access to the My St. Joseph's record of a patient whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in My St. Joseph's. Please note that the patient's chart will be accessed through your (the proxy's) My St. Joseph's record. Completing this form will establish a My St. Joseph's record for you and for the patient.

Your Information: (All sections required – please print clearly) ***(This section should be completed by the individual requesting access to another Patient's My St. Joseph's record)***

Name (last, first, middle initial)_____

Last four digits of Social Security Number:_____

Date of Birth:_____/_____/_____

Street Address: _____

City:_____ State:_____Zip:_____

Email Address: _____

Phone Number: ——————————————

Patient Information: (All sections required – please print clearly) *(This section should be completed with information about the patient whose My St. Joseph's record you are requesting access to)*

Name (last, first, middle initial) ——————————————

Last four digits of Social Security Number:_____

Date of Birth: _____/_____/_____

Street Address: ——————————————

City:_____ State:_____Zip:_____

Email Address: _____

Phone Number: _____

Primary Care Physician:_____

My St. Joseph's Terms and Agreement

- I understand that My St. Joseph's is intended as a secure online source of confidential medical information. If I share my My St. Joseph's ID and password with another person, that person may be able to view my health information.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that My St. Joseph's contains selected, limited medical information from my medical record and that My St. Joseph's does not reflect the complete contents of the medical record. I also understand that a paper copy of the patient's medical record may be requested from St. Joseph's.
- I understand that my activities within My St. Joseph's may be tracked by a computer audit trail and that entries I make may become part of the patient's medical record.
- I understand that access to My St. Joseph's is provided by St. Joseph's as a convenience to its patients and that St. Joseph's has the right to deactivate access to My St. Joseph's at any time for any reason. I understand that use of My St. Joseph's is voluntary and I am not required to use My St. Joseph's or to authorize a My St. Joseph's Proxy.
- By signing below, I acknowledge that I have read and understand this My St. Joseph's Proxy Form and I agree to its terms.

Your (Proxy) Signature *(Required)*	**Relationship to Patient**	**Date** *(Required)*

Signature of Patient *(Required)*	**Date** *(Required)*

Provider Signature *(if required)* _____

Patient Proxy My St. Joseph's Authorization

This form is an authorization that will permit St. Joseph's Hospital to release your medical information to your designated Patient proxy. Please read it carefully.

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in My St. Joseph's. This person is my designated My St. Joseph's proxy. I authorize release of this information only through my My St. Joseph's record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

This authorization will not expire and will remain in effect until I revoke such authorization. I may revoke this authorization at any time by providing a written request for revocation to my provider's office. I understand that if I revoke this authorization, my designated proxy's access to my My St. Joseph's record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

Date:_____

Signature of Patient:_____

Printed Name: _____