AUTHORIZATION (WITH PROXY ADULT)
ACCESS TO ON LINE HEALTH INFORMATION VIA MYPARTNERSHIP

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Social Security Number: _____
(SSN used only to validate during access)

City/State/Zip: _____

Proxy Assignment/Relationship: _____

I understand that access to MyPartnership (on line record) is for access to only my personal health information or information regarding my spouse, parent, or the adult for which I am the legal guardian. **I understand that MyPartnership is NOT to be used in an emergency.**

I understand that sharing my password with anyone else or authorizing proxy allows them access to personal health information, that they could add comments to the medical record, or send messages to the provider. I understand it is my responsibility to maintain my password in a secure manner and to change it if I feel it has been compromised in any way.

I understand that I or my proxy is accessing the following information about myself, my spouse, parent, or the adult for which I am the legal guardian:

- Basic Laboratory Results
- Communication between my provider and myself
- Ability to review, request, or schedule appointments
- Request renewals of prescriptions
- Summary information about my medical history

The reason for this disclosure is to play a more active role in my own health care, of those noted above. I understand that additional information may be made available to me through the MyPartnership product, as Partnership Community Health advances this product.

I understand that my activities within MyPartnership are tracked by computer audit and that entries I make can become part of my medical record or the medical record of those noted above.

I understand that by signing this agreement I am providing Partnership Community Health documentation of my authorization to access my own protected health information as described above or allowing others as noted above. I understand that written request must be made to cancel or revoke this authorization and that any actions taken or accesses prior to that cancellation were authorized as part of the initial signature and date.

I understand that MyPartnership is optional/voluntary and that my provider has the right to deactivate access to MyPartnership for unauthorized or inappropriate actions on my part.

By signing below I am acknowledging that I understand the disclosure of my protected health information. Or, documenting authorization of whom will have proxy to my record. For those adults that I am their legal guardian, this authorization serves as the documentation for the release permission. I certify that I am the parent or legal guardian for the patient named above and that the information I have provided is correct.

Patient/Person Authorized on behalf of patient
Signature_____ Signature Date: _____