PennState Health

MY PENN STATE HEALTH PROXY AUTHORIZATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ Penn State Health Medical Record Number: _____

_____ Primary Phone: _____

PARENT/GUARDIAN/HOME CAREGIVER INFORMATION

Name: _____ Date of Birth:_____

Relationship to patient: ☐ Birth Parent ☐ Adoptive Parent ☐ Legal Guardian ☐ Other:
(Check medical record for documentation of designated representative; If none, then follow prioritization defined in L-07 HAM, "INFORMED CONSENT"). Documentation establishing relationship may be requested.

Address: _____

_____ Primary Phone: _____

_____ Email Address: _____

Penn State Health will send the Proxy listed above a verification email to activate the account and email notifications to manage the account.

By signing below, Proxy agrees to these terms:

- I will use my own user ID and password to access My Penn State Health.
- I will abide by the terms and conditions of the My Penn State Health site.
- Access to the medical record of a patient between the ages of 14-17 will end for the patient, parent and guardians on the patient's 14th birthday, and any further access must be requested at the Penn State Health clinic or community practice site.

Proxy Authorization: I certify that I have the relationship indicated above, to the patient named above. I understand that this patient has granted me continued proxy access to his/her personal health information through My Penn State Health. I further understand that the patient may revoke this access or termination of access at his/her discretion by notifying his/her clinic, community practice site, or Health Information Management, in person or in writing.

_____ _____
Parent/Guardian Signature Date/Time

If patient lacks Decision-Making Capacity (DMC) as defined in L-15 HAM, "PROCEDURE FOR OBTAINING COURT ORDER FOR FILING A GUARDIANSHIP PETITION FOR TREATMENT OF A MINOR OR INCOMPETENT ADULT OR ADULT LACKING DECISION-MAKING CAPACITY," the provider should document the impairment in the medical record and sign here:

_____ _____ _____
Provider Name (Please Print) Provider Signature Date/Time

_____ _____ _____
Witness Name (Please Print) Witness Signature Date/Time

Patient Authorization: I agree to allow the "Parent/Guardian/Adult Proxy"above to have access to my online medical record information, including information that may become available as a result of future medical care. I understand that this proxy account will continue until I revoke it by notifying my clinic, community practice site, or Health Information Management in person or in writing.

_____ _____
Patient Signature Date/Time

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