* 9 2 0 2 0 7 *

PATIENT PORTAL & PROXY ACCESS REQUEST AND CONSENT FORM

Patient Name:

CSN:

DOB: (AGE) Gender:

MRN:

ADM Date:

Complete or AFFIX EPIC LABEL

☐ Patient was offered and accepted the use of an Employed Language Interpreter or Contracted Interpreter Service:

☐ In-Person: ______________________________
Interpreter's Name

☐ Phone: ______________________________
Interpreter's First Name and ID Number

☐ Patient was offered and declined the use of an Employed Language Interpreter or Contracted Interpreter Service:

☐ ______________________________
Name of Interpreter

☐ ______________________________ ______________________________
Relationship Phone Number

IMPORTANT: DO NOT WRITE IN MARGINS

Designating a Proxy: Jefferson patients can give another person the right to see their Jefferson medical record. Proxy access gives the person that you name (your "Proxy") (i.e., parent, legal guardian, or other elected adult) the ability to view your medical record information and talk with your health care providers using the Jefferson Health MyChart ("Patient Portal"). Patient information that may be viewed by your Proxy includes your problem list, allergies, medications, laboratory and radiology results, and other clinical documents. By using the Patient Portal your patient information can be accessed by your Proxy at any time.

You may cancel your Proxy's access at any time automatically through the Patient Portal by clicking the "Preferences" tab and looking under the "Personalize" section. Once you click on the Proxy's name that you wish to deactivate, you can confirm and click on "Revoke Access". This will send a notification to the Proxy that their access has been removed.

You may also revoke your Proxy's access at any time by providing written notification with signature to any one of your provider's offices. Please note that this may take longer than the automatic revocation process via the Patient Portal, as described above.

To request a paper copy of a patient's medical record, please contact Health Information Management at 215-955-6627.

To name a Proxy and/or allow a proxy access to a patient's Patient Portal, please complete the following four (4) pages beginning by providing the patient information requested below:

PATIENT INFORMATION:

Patient Information: (Complete all information. Please print clearly.)

Name (last, first, middle initial): ______________________________

Date of Birth: ______________ Last 4 digits of PATIENT's Social Security No: ______________

Telephone Number: ______________ Mobile Number: ______________

Street Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

E-mail address: ______________________________

PATIENT'S Primary Care Provider: ______________________________

* 9 2 0 2 0 7 *

PATIENT PORTAL & PROXY ACCESS REQUEST AND CONSENT FORM

Patient Name:

CSN:

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ADM Date:

Complete or AFFIX EPIC LABEL

PROXY INFORMATION

*****Please complete the box below that best describes the proxy access requested*****

For all types of proxy access, the patient's medical record will be accessed through the proxy's Patient Portal account.

MINOR PATIENT

Requesting access to a minor child's (age 0-12) Patient Portal.

Individuals requesting access must have parental or legal guardianship rights.

Relationship of Proxy to Minor Patient is:

☐ Parent
- ☐ Is there a court order in effect limiting your access to the minor's medical records and information?
  - ☐ Yes ☐ No

☐ Permanent Legal Guardian of the Minor – You must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship to verify the Proxy's status.

Please Note – Proxy access to 0-12 year old minor's Patient Portal may take 3-5 days.

ADOLESCENT PATIENT

Requesting access to adolescent's (age 13-17) Patient Portal.

Individuals requesting access must have parental or legal guardianship rights.

Relationship of Proxy to Adolescent Patient is:

☐ Parent
- ☐ Is there a court order in effect limiting your access to the adolescent's medical records and information?
  - ☐ Yes ☐ No

☐ Permanent Legal Guardian of the Adolescent – You must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship to verify the Proxy's status.

Please Note – Proxy access to 13-17 year old adolescent's Patient Portal may take 3-5 days.
Please Also Note – When adolescent turns 18, a new request and consent is required to allow Parent/Legal Guardian proxy access.

ADULT PATIENT

Requesting access to another adult's Patient Portal record.

An adult competent patient may select a person to be the patient's proxy. An Emancipated Minor shall be treated as if an adult for purposes of this form. An Emancipated Minor patient may select a person to be the patient's proxy. The Emancipated Minor must provide proof of emancipation.

The adult competent patient must sign the authorization section below to provide authorization for release of their medical information to the named proxy. Authorization for proxy access is valid until revoked by patient.

ADULT PATIENT

Requesting access to another adult's Patient Portal record.

Individuals requesting access must be the adult patient's legal representative.

Relationship of Proxy to Adult Patient is:

☐ Legal Representative of Patient: (Adults who have a surrogate relationship with another adult through a legal arrangement). Select the option below that best describes this Representative relationship:
- ☐ Power of Attorney for Health Care (with current authority)
- ☐ Legal Guardian (court order)

If you are the legal guardian or you have current authority under a durable power of attorney for healthcare for this patient, then this request must be accompanied by a copy of the legal paperwork verifying your authority to have access to the patient's medical information.

You must notify Jefferson immediately of any change in authority.

IMPORTANT: DO NOT WRITE IN MARGINS

PATIENT PORTAL & PROXY ACCESS REQUEST AND CONSENT FORM

Patient Name:

CSN:

DOB: (AGE) Gender:

MRN:

ADM Date:

Complete or AFFIX EPIC LABEL

IMPORTANT: DO NOT WRITE IN MARGINS

PROXY INFORMATION:

Proxy Information: (Complete all information. Please print clearly.)

Name (last, first, middle initial): ____________________

Date of Birth: ____________ Last 4 digits of PATIENT's Social Security No: ____________

Telephone Number: ____________ Mobile Number: ____________

Street Address: ____________________

City: ____________ State: ________ Zip Code: ________

E-mail address: ____________________

PROXY'S Primary Care Provider: ____________________

Does the proxy have an active Jefferson Health My Chart Patient Portal? ☐ Yes ☐ No

Has the proxy ever been a patient at Jefferson? ☐ Yes ☐ No

PATIENT AUTHORIZATION:

I understand and agree that:

- I am allowing Jefferson and its affiliates and contractors to disclose my information on the Patient Portal to the proxy named above, at the request of the proxy from time to time.
- I am responsible to make sure that the information described above, including the email address and other information, is accurate and complete.
- I will comply with the Terms and Conditions of the Patient Portal, as posted at https://jefferson.edu/mychart
- I choose to designate the person named above as a proxy to my Patient Portal and in doing so, allow him/her access to my protected health information.
- I allow the release of any information contained in my Patient Portal to my proxy.
- The medical information in my Patient Portal is obtained from my Jefferson electronic medical record, but is not my complete Jefferson medical record.
- Participating in the Patient Portal and selecting a proxy is completely voluntary.
- I am not required to choose a Patient Portal proxy and I am not required to provide this authorization.
- Jefferson does not condition any of my health care treatment, payment or other services on whether I choose to name a proxy and provide permission by signing this authorization.
- If I do choose a proxy, but do not sign this authorization, Jefferson may not provide access to my Patient Portal to my proxy.
- If I no longer want the proxy to have access to my Patient Portal, I may request that Jefferson revoke his/her access.

By signing below, I acknowledge that I have read, understand and agree to the terms stated above and the Terms and Conditions for Use related to the Jefferson Health My Chart Patient Portal.

Patient
Time ________ **Date** ________ **Print Name** ____________________ **Signature** ____________________

PATIENT PORTAL & PROXY ACCESS REQUEST AND CONSENT FORM

Patient Name:

CSN:

DOB: (AGE) Gender:

MRN:

ADM Date:

Complete or AFFIX EPIC LABEL

PROXY AUTHORIZATION:

I understand and agree that:

- I am the patient's proxy and the proxy information described above is complete and accurate.
- I have read and understand the terms about proxy access noted above under Patient Authorization.
- I have read, understand and agree to the Terms and Conditions for Use related to the Jefferson Health My Chart Patient Portal.
- A patient signature is not required and my signature as proxy is all that is required if I am the proxy for a patient who is a Minor Patient (age 0-12 years of age) or if I am the proxy for a patient because of my legal authority, i.e., legal guardian or power of attorney.
- The Patient Portal contains parts of the patient's medical records, but is not the patient's complete Jefferson medical record.
- Subject to Jefferson's policies and procedures, Jefferson or the patient can revoke the proxy's access to the Patient Portal at any time.
- If I am signing this authorization on behalf of the patient because of my legal authority, I represent and warrant that I am fully authorized to execute this document on behalf of the patient and to access and grant access to information about the patient on the Patient Portal, and I agree that I will notify Jefferson in writing immediately if my relationship or the relationship of the proxy with the patient changes (for example, if I am no longer the guardian of the patient).

By signing below, I acknowledge that I have read, understand and agree to the terms stated above and the Terms and Conditions for Use related to the Jefferson Health My Chart Patient Portal.

Proxy/Patient Representative

Time __________ **Date** _________ **Print Name** ____________________________ **Signature** ______________________________

Relationship to Patient (e.g., parent, legal guardian, etc.) ____

Completed form to be given to Jefferson Staff.

Completed form will be scanned into patient's Medical Record.

Questions? Call MyChart help desk: 215-503-5700

IMPORTANT: DO NOT WRITE IN MARGINS