CHI Mercy Health
Mercy Medical Center

2700 NW Stewart Pkwy
Roseburg, OR 97471
(541) 673-0611

Meditech Patient Portal - Adult Proxy Consent Form

1. Adult Patient Information:

Patient Name: _____ **Date of Birth**: _____
Last First M.I

Address: _____ **Medical Record Number:**_____
Street Address City, State Zip Code **(Optional)**

2. Proxy Information (Parent/Guardian):

Proxy Name: _____ **Date of Birth**: _____
Last First M.I

Address: _____ **Phone Number:** _____
Street Address City, State Zip Code

Email Address: _____

Does the proxy have an active Meditech Portal account? Yes ☐ No ☐

Has the proxy ever been a patient at one of our healthcare facilities? Yes ☐ No ☐

Access to another adult's Meditech Portal record.

(Note: This section also applies to Emancipated Minors. Emancipated Minors must provide proof of emancipation.)

Select one:

☐ **Adult Accessing Adult**

☐ **Personal/Health Care Representative of Adult Patient:** (Adults who have a personal/health care representative relationship with another adult through a legal arrangement.)

Select the option below that best describes the guardianship:

☐ Legal Guardian (court order) ☐ Power of Attorney for Health Care ☐ Other _____

- If you are the legal guardian or you have 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 your healthcare facility immediately in case of any change in authority.

Type of Access to be Granted to Proxy (Select All Applicable):

☐ Full Proxy Access
☐ Billing Summary
☐ Billing Detail
☐ Clinical Data
☐ Download Medical Record
☐ Patient Profile

Authorization by Adult Patient with Decision-making Capacity:

- By signing this proxy request, I understand that I am giving my permission for the healthcare facilities to disclose my protected health information (PHI) through Meditech Portal to my proxy. Information includes but is not limited to health summary, current problem list, current medications, lab results, clinical notes, and appointment information. I understand that if I have given only scheduling and messaging access only, the amount of information that will be available to my proxy will be limited to only the information involved in scheduling and messaging.
- The information available to my proxy may include information related to : (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infections, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request is effective until my Meditech Portal account is inactivated or proxy access is revoked by the patient.
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as my records that are created after the date this form is signed.
- I understand that I have a right to revoke this authorization at any time. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Meditech Portal account will not be granted to my proxy.

Legal Personal Representative:

I confirm that any documents I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify the healthcare facility in writing of the change in authority and mail it to the Health Information Management Department.

X_____ _____

Patient or Legal Personal Representative Signature (Required) Date (Required)

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For HIM Department Use Only:	Date Granted_____	User's initials_____