Avera

PROXACC

LABEL

Proxy Access Form - Addiction Records Only

Access to a patient's AveraChart Record

To request access to the AveraChart record of a patient whose medical care the proxy helps manage, please complete this form. Completing this form establishes an AveraChart for the proxy and for the patient. Please note, the proxy accesses the patient's records through the proxy's access. Each patient and/or proxy must complete a separate form. Please allow approximately seven (7) business days to establish proxy access. After proxy access is established, you get an email to the address provided. Click on the link in the email to gain access to AveraChart. That link expires in 10 days.

Patient Information

Completed by the patient granting AveraChart proxy access.
**** Required Fields.***

*Name (last, first, middle name):_____ *Date of Birth: _____ *Gender: M / F

Last 4 digits of SSN: _____ *Phone Number: _____

Street Address: _____ City:_____ State:_____ Zip: _____

Proxy Information

Completed by the individual requesting access to a patient's AveraChart.
**** Required Fields.***

*Name (last, first, middle name):_____ *Phone Number: _____

Street Address: _____ City:_____ State:_____ Zip: _____

*E-mail: _____

If you are a patient at an AveraChart facility and would also like access to your own record, please provide us with your:
*Date of Birth:_____ *Gender:_____

Authority of Proxy

_____ Patient is an incapacitated person and I am the patient's guardian. See the attached paperwork which is still in effect.

_____ The patient, has authorized my access to medical record information. See Patient section below.

_____ Other: _____

_____

Proxy access for minors is limited to parents and legal guardians.
If proxy access is not authorized, you may request copies of the medical record by contacting Health Information Management at the facility where care was provided.

AveraChart terms and agreement

- I understand that AveraChart is intended as a secure online source of confidential medical information. If I share my AveraChart ID and password with another person, that person may be able to view any health information to which I have access through AveraChart.
- 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 AveraChart contains selected medical information from a patient's medical record and that AveraChart does not reflect the complete medical record.
- I understand that my activities within AveraChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to AveraChart is provided as a convenience to its patients and that access to AveraChart may be deactivated at any time for any reason. I understand that use of AveraChart is voluntary and I am not required to use AveraChart or to authorize an AveraChart proxy.

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Proxy:

I acknowledge and agree that:

- The patient can revoke the proxy access to his/her AveraChart at any time.
- I will comply with the terms and conditions on the AveraChart web page and this document.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I must immediately notify AveraChart in writing of the revocation, termination or expiration and mail it to your: Health facility, Attn: Health Information Management.

▶ _____/_____/ _____

Proxy Signature ***Relationship to Patient*** ***Date***

Patient:

I acknowledge and agree that:

- I will comply with the terms and conditions on the AveraChart web page and this document.
- I choose to designate the person named above as a proxy to my AveraChart, thereby allowing him/her access to AveraChart protected health information, including but not limited to, behavioral health records, and HIV/AIDS test results. I authorize release of any information contained in my AveraChart medical record held by health facilities utilizing AveraChart (a list of facilities can be found at www.averachart.org) to my designated proxy. I understand that the medical information in AveraChart is obtained from my electronic medical record and may include information from all facilities listed in the health facilities' Notice of Privacy Practices.
- I authorize release of this information only through my AveraChart record. This form does not authorize release of my medical record to my designated proxy other than through the AveraChart.
- I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections.
- Participation in AveraChart and designating an AveraChart proxy is completely voluntary. I understand that I am not required to designate an AveraChart proxy and I am not required to provide this authorization. I also understand that the healthcare facility does not condition any of my health care treatment, payment or other services on whether I provide this authorization.
- I understand that if I no longer want the proxy to have access to my AveraChart, I may revoke his/her access in writing by sending a request to my Avera facility to the attention of Health Information Management. A Proxy Revocation form may also be found at www.averachart.org.
- I understand that if I revoke this authorization, my designated proxy's access to my AveraChart will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.
- Unless proxy access is deactivated or otherwise revoked by patient or patient's legally authorized representative, access shall be granted to proxy until termination of patient's AveraChart.
- **Please check only one box below.** If not answered, the proxy will not have authorization to download my entire medical record.

  ❑ I authorize my proxy to download my entire medical record.

  ❑ I do not authorize my proxy to download my entire medical record.

▶ _____/_____/ _____

Patient Signature ***Relationship to Proxy*** ***Date***

▶ _____/_____/ _____

Signature of Legal Representative ***Relationship to Proxy*** ***Date***

Patient signature not required when patient or proxy has legal authority.
Please attach relevant document(s).

Return forms to your:
Health facility
Attn: Health Information Management

HIM use only *(staff initials)*
____Patient signature verified
____Approved by HIM
____Proxy access granted
____Form scanned into medical record