HOAG CONNECT MYCHART PROXY ACCESS FORM – PATIENTS LACKING CAPACITY

hoag.

Parent/Guardian (Minor) or Legal Representative/Conservator (Adults)
Proxy Access to Hoag Connect MyChart for Patients Lacking Capacity

To request proxy access to Hoag Connect MyChart for purposes of accessing the medical record of a patient lacking capacity, please complete this form. A patient lacking capacity is a patient who has been determined by a medical professional or court to lack capacity or competency to make informed decisions about their health care because they are unable to understand the risks and consequences of a procedure or treatment. Please note the individual granted proxy access will do so through their own (the proxy's) Hoag Connect MyChart. The Proxy must obtain their own Hoag Connect MyChart account in order to view the patient's record.

Patient Information: (Completion of all sections required - please print clearly)

Medical Record Number: _____

Patient's Name (last, first, middle initial): _____

Date of Birth: _____

Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Proxy Information:

In order to view the ("Patient's") information, the Proxy must also obtain their own Hoag Connect MyChart account.

Proxy's Name: _____ Date of Birth: _____

Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

☐ Proxy requesting full access to Lacking Capacity Minor Patient (Age 0-17)

☐ Proxy requesting full access to Lacking Capacity Adult Patient (Age 18 and up)

My Relationship to the lacking capacity patient is as follows (mark the appropriate boxes):

☐ Lacking Capacity Minor Patient (Age 0-17)

- ☐ Birth Parent
- ☐ Adoptive Parent
- ☐ Other: list _____
- ☐ Legal Guardian - Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy status as permanent legal guardian of the patient.

☐ Lacking Capacity Adult Patient (Age 18 and up): Basis of Legal Representative Status (select one):

- ☐ Conservator
- ☐ Health Care Agent or Medical Power of Attorney

You must attach proof of your Legal Representative Status.

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PATIENT LABEL

Terms and Conditions for Granting/Receiving Proxy Access

1. I, Proxy, have read, understand and agree to the requirements and procedures for accessing medical information through the Hoag Connect MyChart application as provided in the Hoag Connect MyChart Terms and Conditions of Use which can be reviewed online.
2. I understand that by receiving proxy access, I am allowed to view the contents of the patient lacking capacity's Hoag Connect MyChart record.
3. I understand that the medical information included in Hoag Connect MyChart may include medical information considered very personal, including information about sexually transmitted and other communicable diseases, drug and alcohol abuse, HIV/AIDS, and mental health services. The patient lacking capacity's health care provider, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
4. I understand that access to Hoag Connect MyChart is provided as a convenience to patients and proxies, and that Hoag has the right to deactivate my proxy access at any time for any reason or for no reason.
5. I understand that this authorization will continue until revoked. I may revoke this request for access at any time in Hoag Connect MyChart or may contact Hoag to have my proxy access revoked.
6. I understand that it is my responsibility to terminate my proxy access to my Hoag Connect MyChart account if I no longer wish to have access to Hoag Connect MyChart information. Termination of proxy access is not immediate. Hoag will use its best efforts to terminate your proxy access within ten (10) business days of receiving a written request.
7. If my legal status changes with respect to the patient, I will notify Hoag.
8. If the patient is a minor, as a proxy I have not been denied periods of physical placement and there are no court orders or restraining orders in effect limiting my access to this minor's medical records and/or information.
9. I understand that for all medical emergencies, I need to immediately dial 911.
10. I understand that a member of the patient's care team must sign below to acknowledge.
11. I understand that my proxy access will authorize me to use or disclose the patient's medical information, but only to the extent permitted by the terms and conditions upon my access.

By signing below, I acknowledge that I have read and understand this Hoag Connect Proxy Access Form and agree to the terms and conditions stated herein.

Signature of Proxy: _____ Date/Time: _____

Print Name (Parent/Legal Guardian or Legal Representative): _____

Signature of Patient's PCP or other Care Team Member: _____ Date/Time: _____

Print Name with credential (e.g., RN, MD, etc.) (Care Team or PCP): _____

Please allow 5-10 business days for processing. You will receive a letter with the access code. The access code will be valid for 14 days. You will need the access code to log into the account. It should not be shared with anyone.

Processed by: _____ Date: _____ Time: _____

PATIENT LABEL