Consent - Proxy Auth

Saint Luke's

Proxy Access to the mySaintLuke's Portal Record
Adult Patient Proxy Authorization Form

Please enter **Patient's** information below:

Patient's Name:_____ Medical Record #:_____ (if known)

Address:_____ Last four digits of Social Security #:_____

_____ Date of Birth:_____

Patient's Email Address:_____ Gender: ☐ Male ☐ Female

"I agree to allow the proxy, named below, access to my medical information through mySaintLuke's. I realize that by granting this access, my proxy will have access to the medical information currently available as well as medical information available as the result of future visits. This may include information including records relating to mental health care, communicable diseases, HIV/AIDS, treatment of alcohol/drug abuse and/or genetic testing. I understand I may revoke this access at any time by contacting my provider's office and I will receive an email acknowledging the revocation."

Patient Signature:_____ Date:_____ Time:_____

"I am the patient's legal guardian and can make this authorization on the patient's behalf"

Legal Guardian:_____ Date:_____ Time:_____

Please enter **Proxy** information below:

Name:_____ Email Address:_____

Address:_____ Last four digits of Social Security #:_____

_____ Date of Birth:_____

Phone Number:_____ Gender: ☐ Male ☐ Female

Relationship to patient: ☐ Son ☐ Daughter ☐ Spouse ☐ Other

If Other, please specify:_____

What type of access would you like this person to have to your chart? ☐ Full ☐ Clinical ☐ Scheduling/Messaging

I have read and understand the requirements and procedures regarding accessing a patient's medical record information online as provided on the document titled Proxy Access to the mySaintLuke's Portal Record.

"I acknowledge the following *(initial each)*:

_____ **I and my proxy have read and understand the requirements and procedures for accessing the medical record information online as provided on page one of this document.**

_____ **I and my proxy will not share the created mySaintLuke's User ID and Password with others.**

_____ **Information and alerts regarding mySaintLuke's will be sent to me and my proxy at the email address provided. If no email address is provided, information and alerts will be sent via mail at the address provided.**

_____ **I and my proxy agree to abide by the terms and conditions of the mySaintLuke's site.**

RETURN FORM TO FRONT DESK OF ANY CLINIC/OFFICE or HOSPITAL REGISTRATION

STAFF: Original - email to kcproxyrequest@bjc.org, fax to HIM at 816-891-6072, or interoffice mail to SLN – HIM MSL Team
Copy to patient/guardian