Primary Care Partners
Affiliated with
Atlantic Health System

Dear Patient:

As you approach your 18th birthday and become a legal adult, please understand that your parents or legal guardians are no longer considered your legal representative. Under state law and federal HIPAA regulations, you can consent to your own medical care and control your own medical records and information. This means that we can no longer share your records or any medical information about you with your parents, or anyone else, without your written permission.

We do encourage you to continue to discuss, whenever possible, any health problems or concerns with your parents/legal guardians and to continue to seek their advice. If you would like us to be able to share your information with your parents, legal guardian or anyone else, we ask you to fill out and sign the enclosed **Authorization to Use or Disclose PHI form**. Note that you can specify with whom we can share your information, and the type of information we may share. You are welcome, of course, to bring your parent with you when you visit us in the office.

You will also have access to your Patient Portal at MyChart.com. Through the portal, you can see medical information from your chart, including lab and test results, and ask for appointments, referrals and refills of prescriptions. You can obtain a username and password for your portal from a member in our office. As with your medical care, you can give your parents or legal guardians' access to part of or your entire portal. We have also enclosed **Patient Portal Proxy Access, Request, Authorization, and Acceptance Form** for this purpose.

Please complete and sign the attached authorization forms and return it to us prior to your 18th birthday or as soon as possible thereafter. Should you need to revoke authorization, please contact your office for the proper form.

Sincerely,

Primary Care Partners
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Authorization to Use or Disclosure PHI

Protected Health Information (PHI) Use and/or Disclosure

I do hereby consent to and authorize Primary Care Partners _____(Name of Care Center) to disclose to the person(s) named, information from my medical records relating to my treatment, payment, and healthcare operations as I have indicated below. I understand that this consent shall operate as a complete release of liability to Primary Care Partners, the Care Center and to its employees for the release of information as specified below.

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

This authorization permits Primary Care Partners, _____ (Name of Care Center) to use and/or share with the individuals noted above any part of my individual, identifiable health information, with the exception of information related to:

☐ **Alcohol & Drug use** ☐ **Sexually Activity or Sexually Transmitted Disease** ☐ **Pregnancy** ☐ **Other** _____

I have the right to refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Care Center has acted upon the authorization. My written revocation must be submitted to the Primary Care Partners Care Center.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Primary Care Partners to use or disclose my health information in the manner described above.

Patient Signature _____ Date of Birth _____

Patient Printed Name: _____ Witness _____

Date: _____

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Patient Portal Proxy Access, Request, Authorization, and Acceptance Form

What is this Form?

If you are an adult patient (18 years or older) of Primary Care Partners, you can use this form to request and authorize "Proxy Access" to allow an adult family member or other person involved in your medical care to access, view, and manage certain information in your medical record through your Patient Portal called "MyChart". You can authorize more than one person to have access to your Patient Portal, but you must complete a separate form for each request.

Who can I pick to access MyChart?

You can pick any adult person who is involved in your medical care and who you trust to be granted access to your medical information. Examples include your spouse, parent, sibling, adult child, or other relative. This individual would be called your "**Proxy**" for purpose of your MyChart only. Your proxy can only gain access to your MyChart after you and your proxy complete and sign this form. We may also ask for identification, like photo ID, to verify your proxy's identity.

What can my Proxy see?

Your proxy can see everything in your medical record that you can see through your Patient Portal. In fact, after your Proxy is granted access, he/she would be able to access, view and manage your Patient Portal in the same way you can, including seeing your lab or test results, requesting referrals, requesting or scheduling appointments, paying bills on-line, as well as managing and updating your insurance plan details and personal information. The information your Proxy would see would also include any information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STDs, HIV/AIDS related information, developmental disabilities, and genetic testing results. **Therefore, if you do not want your Proxy to have full access to all information in your medical record, you will need to indicate that accordingly by choosing a Portal Proxy Role on this form.**

What If I Change My Mind Later?

If you change your mind you must inform us immediately that you wish to terminate your Proxy's access to your Patient Portal. Once you sign this form, your Proxy will continue to have access to your medical information through the Patient Portal unless you tell us something different. If your relationship with your Proxy changes, it is your responsibility solely to let us know if you need to terminate your Proxy's access to your medical record. If you do not let us know, your Proxy will continue to have access to your medical record as you authorized by this form.

If you have any additional questions, please ask your Primary Care Partners Provider. You are not required to complete this form or to let any other person have access to your medical record, other than your doctors. The choice is yours. **If you have read this information and still want to grant Proxy Access to a person, you must fill out the rest of this form, and you and your Proxy must sign below.**

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Patient Portal Proxy Access, Request, Authorization, and Acceptance Form

Patient Information:

Patient Name:		**Patient's Date of Birth:**	

Do you currently hold a MyChart account for your personal medical use? ____ Yes ____ No

Proxy Information:

Proxy Name:			
Telephone #:		**E-mail:**	
Address:	street		
	city, state, zip		
	apt#		

___ ID Verification Obtained (*specify type:*_____)

Proxy Relationship to the Patient:

___ Spouse ___ Adult Child ___ Family Member (specify:_____) ___ Other:_____

Proxy Role Options:

- ☐ ***Healthcare Proxy (access to ALL available functions of portal: Demographics, Financials, Clinical, Appointments & Messaging)***
- ☐ Non-Clinical Proxy (access to: Demographics, Financials, Appointments & Messaging)
- ☐ Guarantor (access to Financials only)

Expiration Date/Right of Revocation of Authorization:

This authorization will remain in effect unless revoked or terminated by the patient in writing to the Care Centers Privacy Officer and/or other authorized representative.

By signing below, I confirm as the PATIENT (for allowing access) and the PROXY (for accepting the duties and responsibilities of being granted access to the Patient's medical information) to all of the following REPRESENTATIONS AND WARRANTYS:

- I will not share my confidential log-in credentials with anyone else for use within the Patient Portal;
- I understand that MyChart is not to be used in emergence situations. If there is a medical emergency or an urgent medical question, I will call 911 or contact a Primary Care Partners Provider directly;
- As the Proxy, I have read and understand the requirements for accessing the above named Patient's MyChart account information and agree to abide by the according terms and conditions. My signature represents that all of the information provided about me is correct;
- I understand that this authorization pertains to records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed;
- 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 account will not be granted to the Proxy;
- Neither Primary Care Partners Affiliates or its management company, AHS Investment Corporation, are liable for any unauthorized access to your health information that may result from you and your Proxy not protecting your access credentials;

_____ _____

Signature of **Patient** (or Legal Guardian, if patient minor or incapacitated) Date

_____ _____

Signature of **Proxy** Date