Adult proxy form

Access to another adult's interactive health record

To request access to the interactive health record of an adult whose health care you help manage, please complete this form. The patient must sign this form and provide authorization for release of health information. Please note that the patient's chart will be accessed through your (the proxy's) Allina Health account. Completing this form will establish an Allina Health account for you and access to the adult's interactive health record.

Return all forms to: Account Services or fax 612-262-1424
Mail Route 10607, 2925 Chicago Avenue, Minneapolis, MN 55407

Your information: (all sections required – please print clearly)

This section should be completed by the individual requesting access to another adult's record.

Name *(last, first, middle initial)* _____

Last 4 digits SSN: _____ Date of birth: _____

Street address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ Cuyuna Regional Medical Center
- ☐ FirstLight Health System
- ☐ Glencoe Regional Health Services
- ☐ Hutchinson Health
- ☐ River's Edge Hospital & Clinic
- ☐ Riverwood Healthcare Center
- ☐ St. Croix Regional Medical Center
- ☐ United Family Medicine
- ☐ The Urgency Room
- ☐ Western Wisconsin Health/Baldwin Area Medical Center

Patient's information: (all sections required – please print clearly)

Complete this section with information about the adult whose interactive health record you are requesting to access.

Name *(last, first, middle initial)* _____

Last 4 digits SSN: _____ Date of birth: _____

Street address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ Cuyuna Regional Medical Center
- ☐ FirstLight Health System
- ☐ Glencoe Regional Health Services
- ☐ Hutchinson Health
- ☐ River's Edge Hospital & Clinic
- ☐ Riverwood Healthcare Center
- ☐ St. Croix Regional Medical Center
- ☐ United Family Medicine
- ☐ The Urgency Room
- ☐ Western Wisconsin Health/Baldwin Area Medical Center

Allina Health account terms and agreement

- I understand that my Allina Health account is intended as a secure online source of confidential health information. If I share my username and password with another person, that person may be able to view my or my child's health information, and health information of someone who has authorized me as a proxy.
- 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 confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my email address is current at all times, and that if my email address is not current I will not receive important messages from Allina Health.
- I understand that the interactive health record contains select, limited medical information from a patient's health record and that it does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- I understand that my activities within my Allina Health account may be tracked electronically and that entries I make may become part of the health record.
- I understand that access to the Allina Health account is provided as a convenience to patients and that Allina Health has the right to end access at any time, for any reason.
- I understand that my use of my Allina Health account is voluntary and I am not required to use my account or to authorize a proxy.

▶ _____

Your (proxy) signature *(required)* **Relationship to patient** **Date** *(required)*

I acknowledge that I have read and understand this adult proxy form. I agree to its terms and choose to designate the person named above as my proxy, thereby allowing them access to my interactive health record.

▶ _____

Signature of patient (or authorized person) *(required)* **Relationship to patient** **Date** *(required)*

Adult proxy authorization for release of health information

This form is an authorization that will permit your clinic to release your health information to your designated proxy. Please read it carefully.

This form should be completed by the adult patient who is authorizing another adult to access health information in his or her interactive health record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their interactive health record as a proxy. If you do not have an adult proxy form, please download one from allinahealth.org.

Name *(last, first, middle initial)* _____

Last 4 digits SSN: _____ Date of birth: _____

I am requesting that _____ *(insert name of proxy)* receive access to my interactive health record. This person is my designated proxy. I authorize Allina Health to release the health information contained in my interactive health record to my proxy. I understand that the medical information is obtained from my electronic health record and may include information from all facilities listed in Notice of Privacy Practices. I authorize release of any information contained in my interactive health record to my designated proxy. I authorize release of this information only through my interactive health record. This form does not authorize release of my health record to my designated proxy by other methods or in other forms. 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 the same privacy protections. Accessing my interactive health account and designating a proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. I also understand that Allina Health does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, Allina Health is not permitted to provide my designated proxy access to my interactive health record. This authorization will expire automatically five years from the date of my signature. I also may cancel this authorization at any time online in my Allina Health account or by providing a written request for cancellation to my primary clinic. I understand that if I cancel this authorization, my designated proxy's access to my interactive health record will be ended. I also understand my cancellation will not affect any disclosures that were made prior to processing the revocation before my cancellation request is processed.

Date: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ Glencoe Regional Health Services
- ☐ Riverwood Healthcare Center
- ☐ The Urgency Room
- ☐ Cuyuna Regional Medical Center
- ☐ Hutchinson Health
- ☐ St. Croix Regional Medical Center
- ☐ Western Wisconsin Health/Baldwin Area Medical Center
- ☐ FirstLight Health System
- ☐ River's Edge Hospital & Clinic
- ☐ United Family Medicine

▶ Signature of patient (or authorized person): _____

Printed name: _____

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation:

_____

NOTE: Authorization expires five years from the date of signature (above). This release of health information form must be submitted every five years to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time through your Allina Health account or by providing a written request to your primary clinic.

S410868 B 256985 04/18