Southwest General Partnering with University Hospitals

Southwest General Medical Group, Inc.

Patient Label

HealtheLife Authorization to Use & Disclose Health Information

Instructions: If any section of this form is incomplete, this form may be invalid, which may delay access.

1. *Patient Information:*	
Name: (First, MI, Last)	Phone: Date of Birth:
Current Address:	Email:
City: State: Zip:	***Medical Record Number (Internal Use)***
2. *Understanding Proxy to HealtheLife*	**3. *Proxy Information***
* HealtheLife is a patient portal account containing a subset of the full electronic medical record. * Proxy, for purposes of HealtheLife, is a person authorized to view, download, or transmit ALL patient information available in HealtheLife. * Proxy to HealtheLife remains in effect until revoked by the patient.	Name (First, MI, Last): Phone: Email: *(Proxy email must be different than patient email)*

IMPORTANT NOTE:

If there is health information the patient does not want the Proxy to view, download, or transmit (test results, provider progress notes, operative reports, mental health, OB/GYN services, etc.), the patient should NOT authorize Proxy to their HealtheLife account.

ADOLESCENT / PARENT PROXY

Parents and Legal Guardians of minors generally have access to the patient's medical record without limitations. However, a minor has privacy rights under state law regarding certain services when they consent to such services without parent/guardian consent. As such, Parent/Guardian Proxy access is automatically disabled when the minor reaches adolescent age (13-17 years).

- Parent/Guardian may obtain Proxy access to an adolescent's HealtheLife account with a signed authorization by the adolescent.
- Proxy to HealtheLife remains in effect after the Adolescent turns 18 years old until the patient revokes the Proxy account.

This Authorization grants Proxy access to HealtheLife until revoked by the patient (or their personal representative).

I, the undersigned, authorize the Proxy listed in Section 3 to view, download, or transmit medical information accessible in my HealtheLife patient portal account. This authorization may be revoked in writing to the Health Information Management Department (HIM) (contact information below). I understand revocation will not apply to information that has already been disclosed in response to this authorization. I understand that once the information is released pursuant to this authorization, it may be re-disclosed by the Proxy and the information may no longer be protected by federal privacy regulations. I understand treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand and acknowledge this authorization extends to all or any part of the records accessible in HealtheLife, which may include treatment for physical or psychiatric condition, HIV test results, an AIDS diagnosis, and or alcohol/drug abuse, sexually transmitted infections, and information pertaining to reproductive health and my signing this Authorization grants Proxy the ability to view, download, or transmit such information until I revoke the Proxy account. I expressly consent to the use and disclosure of medical record information accessible in my HealtheLife account.

X _____ _____

Patient or Personal Representative Signature Date

X _____ **PROXY:** X _____ _____

Relationship, if not patient Proxy Signature Date

INTERNAL USE: Date Authorization Received: _____ Processed by (initials): _____

If you have any questions, please call (440) 816-8480.

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