VALLEY HEALTH PARTNERS

PATIENT IDENTIFICATION LABEL

Adult Proxy Form

- **I understand that MyVHP is not to be used for medical emergencies or urgent situations.**
- I understand that MyVHP Proxy provides access to personal health information regarding the adult consenting permission listed on this form.
- The information disclosed in MyVHP will allow me to play a more active role in the healthcare of the patient listed on the "Adult Proxy Form." I understand that additional information may be made available as MyVHP continues to evolve, and that I have agreed to the terms and conditions provided upon my MyVHP account activation.
- I understand that my activities within MyVHP are tracked by computer audits and that entries I make may become part of the medical record of the person listed on the "Adult Proxy Form." This excludes patient or proxy-entered notes that are viewable only by the patient or proxy.
- I understand that a written request must be made to cancel or revoke this authorization and that any actions taken or access prior to cancellation was authorized by my signature and date on the "Adult Proxy Form (Adult to Adult)." I may also revoke this proxy access any time I wish, via the My Family's Records - Family Access Settings in my MyVHP account.
- I understand that Valley Health Partners Community Health Center has the right to revoke access of MyVHP at any time for abusive use of the system.
- I understand that proxy access is granted as a means to participate in the healthcare of the adult patient listed in the "Adult Proxy Form" and direct access to their account is not allowed. I also acknowledge that if the adult patient has problems logging into their own MyVHP account, they must contact support to gain access and that Valley Health Partners Community Health Center MyVHP support can only respond to the account holder for account inquires.

(This form must be completed in the presence of a Valley Health Partners staff member.)

I hereby authorize (Proxy full name) _____ to access my protected health information using MyVHP, and have the ability to act on my behalf via MyVHP, as indicated in the "Adult Proxy Form (Adult to Adult)" document. I may revoke this proxy access any time I wish, by means of my personal MyVHP Account.

X _____ _____/_____/_____

Patient's Signature (Patient Granting Access) **Date (Month/Day/Year)**

I have read and understand the requirements and procedures for accessing a patient's medical record information online as provided above and agree to act as a Proxy for the above mentioned patient.

X _____ _____/_____/_____

Patient's Signature (Patient Requesting Access) **Date (Month/Day/Year)**

X _____ _____/_____/_____

Witness Signature **Date (Month/Day/Year)**

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PATIENT IDENTIFICATION LABEL

Adult Proxy Form

Please fill out all of the required information below in order to have the proxy access created.

Proxy Information – Individual Requesting Access to Another MyVHP Account

Full Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: (_____) _____ **Date of Birth (MM/DD/YYYY):** _____

Social Security Number (XXX – XX - XXXX): _____

Email Address: _____

Relationship to patient: ☐ **Son** ☐ **Daughter** ☐ **Spouse** ☐ **Power of Attorney** ☐ **Other**

If 'Other,' please specify: _____

Proxy Information – Individual Granting Access to Another MyVHP Account

Full Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: (_____) _____ **Date of Birth (MM/DD/YYYY):** _____

Social Security Number (XXX – XX - XXXX): _____

Office Use Only

Patient's Medical Record Number: _____

☐ **Proxy Accounts Linked**

☐ **Form Scanned**