Adult Proxy Form

Thank you for your interest in the FollowMyHealth® at Hendrick patient portal to provide you a convenient and secure way to access to your personal health records from any computer, smartphone or tablet with internet access.

Instructions for Proxy Access to Another Adult's FollowMyHealth® Record

To request proxy access to view an adult's health information using FollowMyHealth®, the **patient or their legal representative** must complete this "Adult Proxy Form" and the "Authorization for Release of Medical Information to Adult Proxy" Form and return to:

Hendrick Health Information Services, 1900 Pine Street, Abilene, Texas 79601-2432
Phone: (325) 670-2407 Fax: (325) 670-6538
Monday – Friday 8:00 AM – 4:30 PM and Closed Holidays

After the form is received and verified, you will receive an e-mail with further instructions. In order to set up a proxy account, you must first have your own FollowMyHealth® account that can be set up by logging into: www.hendrickhealth.org/FollowMyHealth

Patient's Information: (The person whose FollowMyHealth® record is being requested)

_____ _____ / _____ / _____
Print Name (Last, First, Middle Initial) Date of Birth

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____
Last 4 of SS# Phone Number Email Address

Proxy Information: (Person viewing patient's record)

_____ _____ / _____ / _____
Print Name (Last, First, Middle Initiatl) Date of Birth

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____
Last 4 of SS# Phone Number Email Address

_____
Relationship to Patient

I acknowledge that I have read and understand this FollowMyHealth® Sign-up Form.

_____ _____
Signature of Patient (or authorized person) Date

_____ _____
Proxy Signature Date

Please include a copy of your identification (i.e. driver's license, passport) as this will need to accompany your request for access to FollowMyHealth®. If additional information is needed for verification a representative from Hendrick Information Services will contact you. Please allow up to 5 business days to complete your request.

For Official Hendrick Health Systems Use: Identification Verified by _____ MRN _____ Date Invite Sent _____

Authorization for Release of Medical Information to Adult Proxy

This form authorizes Hendrick Health System to release your medical information to your designated adult proxy. Please read it carefully before completing. This form is to be completed by the patient who is authorizing another adult to access medical information in his or her FollowMyHealth® 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 FollowMyHealth® record as a proxy.

_____ _____ / _____ / _____

Print Name (Last, First, Middle Initial) Date of Birth

I am requesting that _____ (name of proxy) receive access to my health information that is available in my FollowMyHealth® record. This person is designated as my FollowMyHealth® proxy. I authorize Hendrick Health System and FollowMyHealth® to provide proxy access to the health information within my FollowMyHealth® record to my designated proxy. I understand that the medical information in FollowMyHealth® is obtained from my electronic medical record and may include information from all Hendrick Health System facilities but is not a complete medical record.

I authorize release of this information only through my FollowMyHealth® record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms, without additional authorization.

I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information is not covered by federal privacy protections.

Participation in FollowMyHealth® and designating a FollowMyHealth® proxy is voluntary. I understand that I am not required to designate a FollowMyHealth® proxy and I am not required to provide this authorization. I also understand that Hendrick Health System 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, Hendrick Health System is not permitted to provide access to my FollowMyHealth® record to my designated proxy.

This authorization will expire upon revocation, or on the date or event specified here _____. I also may revoke this authorization at any time from within my account or by providing a request for revocation to Hendrick Health System's Health Information Services. I understand that if I revoke this authorization, my designated proxy's access to my FollowMyHealth® record will be terminated. I also understand that my revocation will not affect any disclosures that were made prior to processing the revocation request.

_____ _____

Signature of Patient (or authorized person) Date

_____ _____

Printed Name Relationship to Patient

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

_____

Please include a copy of your identification (i.e. driver's license, passport) as this will need to accompany your request for access to FollowMyHealth®. If additional information is needed for verification a representative from Hendrick Information Services will contact you. Please allow up to 5 business days to complete your request.