myhealth
Lutheran Health Network

PATIENT-DESIGNATED PERSONAL REPRESENTATIVE AND OTHER AUTHORIZED USER ACCESS REQUEST

PATIENT INFORMATION

Printed Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Telephone number: _____

I authorize Lutheran Health Network and its affiliated healthcare providers to share health information about me, or the patient for whom I am the legal representative, as described below.

THE FOLLOWING PERSON MAY RECEIVE PROTECTED HEALTH INFORMATION FROM MY ACCOUNT BY HAVING ACCESS TO MY RECORDS THROUGH THE FOLLOWMYHEALTH WEB PORTAL. I AUTHORIZE THE PERSON INDICATED BELOW TO REQUEST THE ABILITY TO ACTIVATE AN ACCOUNT ON MY BEHALF, IF I DO NOT ALREADY HAVE A FOLLOWMYHEALTH ACCOUNT.

Printed Name: _____ DOB: _____

Relationship to Patient: _____

Email: _____ Telephone number: _____

❑ Check here if same address as above patient. *If address is different, please provide:*

Address: _____

City: _____ State: _____ ZIP: _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to, information related to the following types of records or information: billing and account statements, prescription drug information, secured email transmissions between myself and Lutheran Health Network, and clinical testing and laboratory results, including but not limited, to genetic testing information, mental health treatment information (excluding psychotherapy notes), infectious disease information (including HIV status), medical research records of both open and closed trials (where applicable), information regarding mental, physical or sexual abuse; and substance abuse treatment information. Lutheran Health Network may, within its discretion, elect to withhold from disclosure any of the above information that contains particularly sensitive information.

Protected Health Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by the Health Information Portability Accountability Act (HIPAA).

DESIGNATED REPRESENTATIVE ACCESS LEVEL:
(Only one access level allowed per designated representative)

_____ **'READ ONLY ACCESS'** only allows the Healthcare Proxy to view their proxy accounts.

_____ **'FULL ACCESS'** allows the Healthcare Proxy to have full functionality of their proxy accounts. **For minor proxies, full access is the only option.**

Patient/Parent/Guardian/Legal Representative Signature: _____

Date: _____ Time: _____ Witness Signature: _____

*Completed document should be scanned into AMR and placed under Consents with an Internal Note of Patient Portal.