Roane General Hospital
Care you can trust. . .close to home

MyRGHchart Proxy Request and Authorization Form

Patient's Name: _____ Date of Birth: _____ / _____ / _____

Patient's Medical Record #:_____ Patient's SS#:_____

Patient's Telephone #:_____ Patient's Email: _____

Patient's Current Address: _____

Proxy Requestor's Name (Print): _____

Proxy Requestor's Email: _____

Proxy Requestor's Telephone Number: _____

Please check the Proxy Requestor's relationship to the patient:

Adult Patients
__ Medical Power of Attorney (MPOA)/Durable Power of Attorney for Healthcare (DPOA) **
__ Adult Child of Disabled Parent**
__ Parent of Disabled Adult Patient**
__ Legal Guardian of Disabled Adult Patient**
__ Adult Child of Senior Parent (*Both Patient and Proxy Requestor must sign below.*)
__ Caregiver for Adult Patient (*Both Patient and Proxy Requestor must sign below.*)

Minor Patients
__ Custodial Parent of Minor (age 12 or under)
__ Legal Guardian of Minor (age 12 or under) **
__ Non-Custodial Parent of Minor (age 12 or under)
Is there a court order or a restraining order in effect limiting the requesting individual's access to this child's medical records and information?
_____
Please Write: Yes/No
If yes, please provide legal documents **

__ Parent/Guardian of Teenage Minor (age 13–17) (*Both Patient and Proxy Requestor must sign below.*)
__ Legal Guardian of Disabled Minor **

***This request **MUST** be accompanied by a copy of legal documents verifying the authority of the patient's personal representative (i.e. court appointed guardian, medical power of attorney, durable power of attorney for health care).*

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Patient Authorization: By signing this proxy request, I acknowledge and understand that:
• The purpose of this document is to give my permission for Roane General to disclose my protected health information (PHI) through MyRGHchart to my proxy named on page one of this document. This covers all of my PHI, which may include, but is not limited to: health summary, current problem list, current medications, lab results, appointment information.
• The information available to my proxy may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
• This proxy request is effective until my MyRGHchart account is inactivated or proxy access is revoked.
• This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that are created after the date this form is signed.
• I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my proxy.
• I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.
• I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my MyRGHchart account will not be granted.

Patient Signature: By signing below, I acknowledge and agree with the terms of this document.

X_____ _____ _____
Patient or Legal Representative Signature Relationship to Patient Date

Proxy Authorization: By signing this proxy request, I acknowledge and represent that:
• I have rights as either a parent, legal guardian, Medical Power of Attorney designee, or other person authorized by the patient or by a court order to access this patient's record.
• I have not been denied periods of physical placement with the patient and there are no court orders or restraining orders in effect limiting my access to this patient's medical records and/or information.
• For a child age 0 to 12 years, I will be granted full access to the child's MyRGHchart account. On the child's 13th birthday, I will no longer have access to the child's MyRGHchart unless the child or a court order authorizes proxy access.
• Any documents, if any, I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify Roane General Hospital in writing of the change in authority.
● Any competent adult or child age 13 or over may revoke access to his/her MyRGHchart account at any time.

Proxy Signature: By signing below, I acknowledge and agree with the terms of this document.

X_____ _____ _____
Proxy Signature Relationship to Patient (Required) Date

MyRGHchart Proxy Request and Authorization Form

Witness: I acknowledge that I verified the identity of the individuals and the signatures on this Proxy Request and Authorization Form were made in my presence.

X_____ _____ _____

Witness Signature | Relationship to Patient | Date