Carle

MYCARLE PROXY AUTHORIZATION FORM

PATIENT INFORMATION – All fields are required.

Patient Name:_____

MRN#:_____ Last 4 Digits of SS#:_____ Date of Birth:_____

Address:_____

City, State, Zip:_____ Phone #:_____

AUTHORIZING ACCESS FOR:

Check box that indicates patient status.

☐ Child (Birth through 11 years of age) **Sign Box A**

☐ Adolescent (12 through 17 years of age) **Sign Box B**

☐ Adult (18 and older) **Sign Box B**

PROXY INFORMATION – All fields are required.

Person who will be receiving access to patient's health information.

Proxy's Name:_____ Date of Birth:_____

Address:_____

City, State, Zip:_____ Phone #:_____

Is the Proxy a Carle patient?

Selecting yes indicates that Proxy requestor has a PCP or Specialist at Carle.

☐ Yes If yes, please provide the last 4 digits of SS#_____ and medical record number #_____

☐ No If no, please provide <u>all</u> 9 digits of SS#_____-_____-_____

Please note that the social security number is required for authentication purposes and will be stored securely in compliance with applicable law.

AUTHORIZATION SIGNATURES

BOX A: I have read and understand the requirements for accessing the above-named patient's MyCarle Online account and agree to abide by these requirements. This access will expire on the patient's 12th birthday. A photocopy of this Authorization is as valid as the original. I certify that all the information I have provided is correct. I hereby request access to the above-named patient's MyCarle Online account.

_____ _____

Signature of Parent or Legal Guardian Date Signed

BOX B: I understand MyCarle Online will display medical information to the proxy requestor listed above. I have read and understand the guidelines regarding MyCarle Online account information including secure patient messaging and agree to allow the requestor listed below access to MyCarle Online account information. I also agree to abide by the terms and conditions for use of MyCarle Online. I understand that if I opt out of receiving any notification/alerts to my MyCarle account, the proxy requestor above will continue to receive such notifications including but not limited to emails and text messages.

_____ _____

Signature of Patient or Legal Representative Date Signed

Internal Use Only:

Patient or Parent/Legal Guardian have presented in person with completed application. Employee's initials:_____

Employee's location:_____ Date:_____

Once completed please route to **HIRR** for scanning.