Kelsey-Seybold Clinic

Your Doctors for Life

ADULT PROXY/RELEASE OF INFORMATION FORM

MRN #: _____
Patient Name: _____
Provider: _____
Provider #:_____
Date: _____
Submitted By: _____

This form is an authorization that will permit Kelsey-Seybold Clinic to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyKelseyOnline account.

Access to Another Adult's MyKelseyOnline Account

To request access to the MyKelseyOnline record of an adult whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyKelseyOnline. Please note that selected information from the patient's chart will be accessed through your (the proxy's) MyKelseyOnline account.

Your Information (All sections required – please print clearly.)

This section should be completed by the individual requesting access to another adult's MyKelseyOnline account.

Name (*last, first, middle initial*) _____ Date of Birth: _____

Email: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____

Patient's Information (All sections required – please print clearly.)

Complete this section with information about the patient whose MyKelseyOnline account you're requesting to access.

Name (*last, first, middle initial*) _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in MyKelseyOnline account. This person is my designated MyKelseyOnline account proxy. I authorize Kelsey-Seybold Clinic to release the health information contained in my MyKelseyOnline account to my MyKelseyOnline proxy. I understand that the medical information in MyKelseyOnline is obtained from my electronic medical record and may include information from all facilities listed in Kelsey-Seybold Clinic's Notice of Privacy Practices. I authorize release of any information contained in my MyKelseyOnline medical record held by Kelsey-Seybold Clinic to my designated proxy.

I authorize release of this information only through my MyKelseyOnline account. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy. I acknowledge that I have read and understand this MyKelseyOnline Adult Proxy/Release of Information form. I choose to designate the person named above as my MyKelseyOnline Proxy, thereby allowing them access to my MyKelseyOnline account.

Participation in MyKelseyOnline and designating a MyKelseyOnline proxy is completely voluntary. I understand that I am not required to designate a MyKelseyOnline proxy and I am not required to provide this authorization. I also understand that Kelsey-Seybold Clinic 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, Kelsey-Seybold Clinic is not permitted to provide access to my MyKelseyOnline account to my designated proxy.

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Revocation can be completed on-line through your MyKelseyOnline account or in writing and delivered to the Kelsey Seybold Clinic, Attn: HIM & Privacy Office, 560 Meyerland Plaza, Houston, TX 77096. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Date: _____

Signature of Patient (or authorized person): _____

Printed Name: _____

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

_____

Signature of Proxy: _____

Printed Name: _____