PROXY ACCESS REQUEST

Patient information: (Patient to which CCM Health portal proxy access is requested, ONE patient per form)

Patient name: _____ _____
Last name First name MI Previous or other names used

Address: _____
Street Address City, State Zip Code

Date of birth: _____ Phone number: _____ Last 4 digits of SSN: _____

Requestor (proxy) information: (Person to whom you authorize CCM Health to release the CCM Health record)

Proxy name: _____ _____
Last name First name MI Previous or other names used

Address:_____
Street address City, State Zip code

Email: _____ Phone number: _____

Please note that for all types of proxy access, the patient's chart will be accessed through the proxy's CCM HEALTH portal account.

_____ **Child Proxy Access**

_____ **Adult Proxy Access** (Access to another adult's CCM Health record)
The patient must sign this form to provide authorization for release of medical information. Authorization for proxy access to an adult patient's account is valid until revoked by the patient.

_____ **Legal Guardian**
Documentation Required. If you are the legal guardian or have a durable power of attorney for healthcare with regard to the patient, then this request MUST be accompanied by a copy of legal paperwork verifying your authority to have access to the patient's medical information. Select the option below that best describes the guardianship:

_____ Legal Guardian (court order): _____

_____ Power of Attorney for Health care (activation): _____

_____ Other: _____

Form continues on back side – signature required.

• By signing this proxy request, I understand that I am giving my permission for CCM Health to disclose my protected health information (PHI) through CCM Health to my proxy. Information includes, 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 CCM Health portal account is inactivated or proxy access is revoked and 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 may revoke proxy access at any time: 1) By notifying CCM Health in writing to CCM Health, Health Information Management, 824 N 11th St., Montevideo, MN 56265 or by fax at (320) 269-8186 of my intent to revoke an individual's proxy access.

• I understand that such a revocation will not have any effect on any information already released to my proxy.

• If neither federal nor Minnesota privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Minnesota privacy laws.

• Proxy request is voluntary and I may refuse to sign this form. I understand that I am not required to sign this Authorization Form in exchange for receiving treatment from CCM Health.

• Any documents, if any, I have provided to 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 CCM Health in writing of the change in authority and mail it to CCM Health, Health Information Management, 824 N 11th St, Montevideo, MN 56265 or fax at (320) 269-8186.

(Child Proxy Access)
Signature of Parent or Guardian _____

(Adult Proxy Access)
Signature of Patient or Authorized Personal Representative: _____

Relationship to the Patient
(If signed by a Personal Representative): _____

Date: _____

If person other than the patient signs, indicate authority to sign for patient and attach documentation.

CCM HEALTH OFFICE USE ONLY

Please check one: ___ Approved ___Denied, Reason for denial: _____