MyHealthAdvantage

MyHealthAdvantage Proxy Authorization Form

PLEASE PRINT THE PATIENT'S INFORMATION IN THIS BOX

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ / _____ / _____ Medical Record Number (MRN): _____
Month Day Year

I understand that Hawaii Pacific Health and its affiliate health care providers (collectively, "HPH") share an integrated electronic medical record. I also understand the general policy of HPH is not to disclose my/my child's protected health information (PHI) to others unless they are directly involved in my care, without my authorization or as permitted or required by law. Therefore, I authorize HPH to grant MyHealthAdvantage proxy access to the person(s) named below for the purpose of assisting with or facilitating the coordination of my/my child's health care. I understand this does not allow those identified to make health care decisions for me/my child or to have full access to my/my child's records.

Proxy(s) Printed Name (Attach a separate form for additional names)		**Proxy(s) Relationship to Patient** (Example: Wife, Son, Father, Etc)		**Proxy(s) Date of Birth** (Month, Day, Year)
1.				/ /
2.				/ /

Scope of Authority: My authorization to grant MyHealthAdvantage proxy access to the above person(s) includes the authority to discuss my care with my physician(s), to view, update and/or make changes to the following information in MyHealthAdvantage:

- Financial information such as billing, payment, my insurance information;
- Health care information such as information regarding my condition and/or treatment;
- Viewing and or making and changing appointments; and
- Making changes to demographic information such as address, phone, e-mail, etc.

Sensitive Information: I understand my health information and financial records may contain or reference sensitive health information such as drug or alcohol abuse, mental health and HIV/AIDS status. I understand sensitive information related to lab tests and certain diagnoses may not be included in MyHealthAdvantage.

Proxy Access: Except as indicated above, proxy access to MyHealthAdvantage permits my designated proxy(s) to view everything I can see, including but not limited to: my problem list, medication list, medical history, messages between me and my doctors, past and future appointments, and test results. My proxy will also be able to send messages on my behalf.

Voluntary: This authorization is voluntary. I understand I do not have to sign this form. This facility will not condition my care or its services on receiving this authorization. I will receive a signed copy of this authorization.

Re-Disclosure: I understand that granting proxy access to MyHealthAdvantage means the information may no longer be protected by federal privacy regulations.

Expiration: I understand that this authorization will expire automatically when the patient turns 14 yrs of age (authorization becomes limited to messaging function). Otherwise, this authorization does not expire unless an Expiration date is indicated below.

☐ End Date: _____ / _____ / _____
Month Day Year

Right to Revoke: I understand that I may revoke my proxy's access at any time by going into MyHealthAdvantage and selecting revoke access or by notifying HPH in writing. I also understand that revoking this authorization will not apply to any information disclosed to your authorized proxy before HPH received the revocation. (See our *Notice of Privacy Practices* for instructions).

My Responsibility: I understand it is my responsibility to update this information as needed.

Signature of Patient and/or Legal Guardian _____

Print Name _____ **Date** _____

If signed by someone other than the patient, please describe your legal authority to act on behalf of the Patient:

KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN · PALI MOMI MEDICAL CENTER · STRAUB CLINIC & HOSPITAL · WILCOX HEALTH

HAWAI'I PACIFIC HEALTH