Trinity Health Of New England | Medical Group

Adult Accessing Adult Proxy Form

****This form is intended to be used by (1) a patient wishing to designate another adult individual as his/her personal representative (as permitted under the Health Insurance Portability and Accountability Act (HIPAA)) with authority to access the patient's health information available through the Site, as defined below, and (2) the personal representative requesting access to the Site on behalf of the patient. Please note that Trinity Health of New England Medical Group, in its sole discretion and in accordance with applicable law, may refuse a personal representative's request to access a patient's health information if Trinity Health of New England determines it would not be in the best interests of the patient.*

Trinity Health of New England offers information, including access to patient certain health information, via a Web-based version of our computer systems called MyChart (the "Site"). Please note that not all of a patient's Trinity Health of New England's health information will be accessible through the Site. Please refer to Trinity Health of New England's Notice of Privacy Practices for a description of how to obtain a copy of a patient's Trinity Health of New England medical record.

Please bring this completed form and proper identification to Trinity Health of New England's Health Information Management Dept. in our Chicopee, Agawam or Springfield sites. If you are a Westfield or Wilbraham patient, you may give this form to a receptionist who will forward it via interoffice mail.

Patient's Information and Designation of Personal Representative (All sections required – please print clearly.)

Patient's Information:

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

Social Security #:_____Email: _____

Street Address:_____City:_____State:_____Zip: _____

Phone Number: __(_____)_____ PCP: _____

☐ Verified ID Location:_____Employee: _____

Designation of Personal Representative:

I understand that my designation of a Personal Representative with authority to access my health information through the Site is voluntary, that by signing this form I am authorizing Trinity Health of New England to disclose my personal health information to the individual named below, and that the information, once released, may no longer be protected by federal privacy regulations. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon my signing this designation.

I understand that my health information available through the Site MAY or MAY NOT contain sensitive information that is statutorily protected. I specifically acknowledge and agree that all health information available to me through the Site will be available to my designated Personal Representative, which may include, without limitation, HIV testing and related information, mental health and substance abuse information, abortion information, genetic information, sexually-transmitted disease information, and domestic violence/sexual assault information. *If you do not wish to make such sensitive health information available to your Personal Representative, do not sign this form.*

I hereby designate the following individual as my Personal Representative and authorize the following individual to access my health information, including my personal health information as defined under the Health Insurance Portability and Accountability Act (HIPAA), through the Site.

Name (*last, first, middle initial*) _____ Relationship: _____

I understand that I may revoke this designation from within the MyChart website and by notifying Trinity Health of New England in writing at the following address:

Health Information Management Dept.
444 Montgomery Rd
Chicopee, MA 01020

However, revocation shall not affect any disclosures already made by Trinity Health of New England in reliance on this designation and authorization. I understand that I may also de-activate my Personal Representative's proxy access from within my MyChart Account under the activity labeled *My Family's Records* by going to the section called *Family Access Settings*.

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

This section should be completed by the individual requesting access to the Site as the Personal Representative designated above. Verification of identity must be supplied.

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

Social Security #:_____Email: _____

Street Address:_____City:_____State:_____Zip: _____

Phone Number: _____

Agreement and Acknowledgement

- I understand that the Site is intended as a secure online source of confidential medical information. I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that the Site contains selected, limited medical information from the patient's medical record and that the Site does not reflect the complete contents of a patient's Trinity Health of New England medical record. I also understand that a copy of the patient's medical record may be requested from Trinity Health of New England's Health Information Department.
- I understand that my activities within the Site may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to the Site is provided by Trinity Health of New England as a convenience to its patients and their legal representatives and that Trinity Health of New England has the right to deactivate my access to the Site at any time for any reason. I understand that use of the Site is voluntary and I am not required to use the Site.
- I acknowledge receipt of, and agree to comply with, all Terms and Conditions applicable to the Site, as attached hereto,
- By signing below, I acknowledge that I have read and understand the contents of this form and the Terms and Conditions and I agree to all terms.

I certify that all information I have provided above is correct.

▶ _____ / _____

Signature of Patient **Date** *(Required)*

▶ _____ / _____

Signature of Personal Representative **Date** *(Required)*